Barriers to accessing mental health services in Somali-Australian women: a qualitative study

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ORIGINAL ARTICLE

Barriers to accessing mental health services in Somali-Australian women: a qualitative study

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ABSTRACT: *Despite the global prevalence of mental disorders being widely acknowledged, mental illness, complex trauma and the significant impact on individuals, families and communities continues to be poorly recognized, under-diagnosed and underreported. Based on the 2017 Australian census, one-in-five (20%) people have experienced some type of mental illness within the last 12 months (Australian Bureau of Statistics [ABS], 2019). The prevalence rate of mental illness in culturally and linguistically diverse (CALD) communities is difficult to estimate due to cultural and linguistic issues and underutilization of mental health services. In particular, little epidemiological data is available about the prevalence of mental illness in the Somali-Australian community. The aim of this study was to identify the perceived barriers to help-seeking for mental health for Somali-Australian women. A qualitative descriptive study incorporating focus group discussions with 31 Somali-Australian women was conducted in Melbourne, Australia. Braun & Clarke's (2006) thematic analysis was applied to the data. Four themes relating to help-seeking barriers were abstracted. Influence of faith explored how Islam can impact the person views on mental illness. Stigma focused on the relationship between public and self-stigma and help-seeking. Mistrust of Western healthcare system describes the participants concerns about the cultural disconnect between the community and the Western healthcare system. Finally, denial of mental illness reflected the community views on mental health. This study provides an insight into the factors that influence the Somali-Australian community help-seeking with mental health services. The findings have implications for mental health professionals and the Somali-Australian community.*

KEY WORDS: *African migrants, barriers, focus groups, help-seeking, mental health, mental illness, qualitative research, Somali-Australian women.*

INTRODUCTION

Somalia, a country located on the east coast of Africa, has an extensive history of colonization, civil unrest and natural disasters (Worldwatch Institute 2018). These historical and current events forced Somali people to migrate to surrounding sub-Saharan African and Western countries (Connor & Krogstad 2016). Pre-migration stressors including traumatic experiences, famine, poverty, displacement and violence can have devastating impact on the mental well-being of individuals, families and communities (Kirmayer *et al*. 2011). Post-migration

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stressors such as unemployment, low socioeconomic status and poor housing, can contribute to the development of common mental illnesses (Veysi *et al*. 2017). People who experience pre and post migration stressors are at a higher risk of developing mental illness such as post-traumatic stress disorder (PTSD), depression, psychosis and experience suicidal ideations and substance abuse (Kirmayer *et al*. 2011).

There is limited research available on the incidence rate of mental illness for migrants in Australia. This is concerning as the 2016 census reports that 49% of Australians were either born overseas or had one or both parents born overseas (ABS 2017). Additionally, at the end of 2019, there were over 7.5 million (29.7% of the population) migrants living in Australia (ABS 2020). In 2019, O'Donoghue et al. analyzed data from first-generation migrants aged between 15 and 24 years in Melbourne diagnosed with first episode psychosis residing in the north west region of Melbourne. The study highlighted first-generation young people who migrated from sub-Saharan Africa experienced a higher risk of developing a psychotic disorder in comparison with Australian-born individuals. Migrants from Kenya particularly experienced over a 10-fold increased risk, followed by Sudan (7%), Ethiopia (5.5%) and Somalia with almost 4% (O'Donoghue *et al*. 2019).

Stigma is a significant barrier for individuals with mental illness to seek help (Boardman *et al*. 2011; McCann *et al*. 2016; Minas *et al*. 2013). Public stigma refers to the negative attitudes that are held by the public towards people with mental illness and the discriminating behaviour directed at them (Corrigan & Rao 2012). Public stigma can influence the individual with mental illness to use secrecy as a coping strategy by not disclosing their diagnosis or symptoms due to feelings of shame, guilt and hopelessness. Self-stigma occurs when public stigma is internalized and the individual with mental illness is reluctant to seek any professional help (Corrigan & Rao 2012; Corrigan & Watson 2002). In Somali culture, it is common for mental illness to be stigmatized publicly and this causes people to then experience self-stigma. Experience of mental illness is generally denied with individuals reporting physical pain than psychological symptoms when experiencing mental distress (Carroll 2004; World Health Organization 2012).

The term first-generation in this study refers to either a foreign-born person who has migrated and become a citizen in the new country or children born in the new country whose parents are immigrants (Merriam-Webster, n.d). The term migrant in this study includes those who arrive in Australia under skilled migration, sponsored family members or refugee and humanitarian programs (Australia Government, n.d).

AIM/QUESTION

The aims of the study were to explore first-generation Somali-Australian women's understanding of mental health and illness, and to understand their perceived barriers to help-seeking for mental health problems.

METHOD

The study incorporated a descriptive qualitative design. Qualitative research focuses on understanding people's beliefs, experiences, interactions, behaviour and attitudes in the world in which they live. Qualitative research is ideal when researchers seek to (i) explore individual stories, (ii) write about the stories in creative and flexible styles, (iii) understand the context of issues, (iv) explain the link in casual theories, (v) develop theories and (vi) when quantitative statistical methods do not apply to the research problem (Creswell 2014).

Data collection occurred between December 2017 and March 2018, incorporating audio-recorded focus group discussions that were transcribed verbatim. Focus group discussions were facilitated by the researcher using a semi-structured interview schedule. Data was analyzed following Braun and Clarke's (2006) thematic analysis in order to identify, analyze and report on themes.

Recruitment

The participants were recruited based on purposive sampling. Inclusion criteria were (i) women aged 18 years and over; (ii) identified as first-generation; (iii) ability to communicate in conversational English. The only exclusion criterion was the participant was not receiving treatment for an acute episode of mental illness.

An information poster including a summary of the project, participant and contact details were distributed to two universities student notice boards across three campuses, professional bodies such as HealthWest, Mercy Mental Health and Western Young People's Independent Network, community and social networks (including social media). Participant recruitment was sporadic and difficult because this group of women were hard to access due to the nature of this group and took several months. Therefore, to aid in

recruitment, snowball sampling was utilized. In total, 31 first-generation Somali-Australian women participated in this study.

ETHICS

Ethical approval was acquired from a University Human Research Ethics Committee for a low-risk study (HRE17-214). All participation was voluntary, and participants were advised they had the right to withdrawal at any stage without explanation. Participants were advised they did not need to answer any questions if they felt uncomfortable in answering. Anonymity was maintained and all identifiable information was removed from all published reports to safeguard the participants' privacy. No participants withdrew from the study nor reported feeling uncomfortable with questions asked.

RESULTS

A total of 31 first generation Somali-Australian adult women (hereafter, the women) participated in this study. The mean age of the women were 23.1 years, ranging from 18 to 34 years. Ten women migrated to Australia at an early age, and the other 21 women were born in Australia. Approximately, two-thirds (n = 18) resided in the western suburbs of Melbourne, while the reminder resided in the northern and south-eastern suburbs. Regarding post-compulsory education, five of the women had completed an undergraduate degree and were pursuing further postgraduate qualifications, while the remainder (n = 26) were undertaking their bachelor studies. Four central help-seeking barriers were identified from the data: influence of faith, impact of stigma, mistrust of Australia healthcare systems and denial of mental illness.

Influence of faith

Religion played a vital role in the lives of the women who were interviewed. Islam as a central theme came across strongly throughout the data. Islamic faith was perceived to be a barrier to help-seeking, if the individual experiencing a mental health issue was not a devout Muslim.

> But someone who is not very connected to the deen (religion) you can't tell them it's part of God's plan, as this might push them away (from the religion and community) [FGD 4, Participant 5]

As Muslims believe everything is preordained by God, the participants reported that they interpreted mental illness as a test from God. If someone experiences and endures the mental illness, they will have a better afterlife.

> You can ask Allah (God) to heal you (from your illness), or you can keep your illness, and then you'll go to Paradise. As the more suffering you endure, the greater the benefits. [FGD 1, Participant 5]

The impact of stigma

The impact of stigma about mental illness in the Somali-Australian community was evident. One of the women explained how public and self-stigma interfered with a person disclosing their mental illness.

> It's very rare that your (mental) illness is actually making you violent. And I think that that's something that definitely comes from the stigma of people being afraid of people with mental illnesses. And I agree with you about the hierarchy of mental illness. If I say, 'I have depression', it's a lot easier (for the community) to swallow (to accept), especially for our generation, than if I say, 'I have schizophrenia or bipolar [disorder]'. And so, people are still skirting around certain disclosers or diagnoses because they don't want to be the person who has schizophrenia (self- stigma), or that person who has bipolar (due to community stigma of people with mental illness). [FGD 1, Participant 4]

Another participant described how the Somali-Australian younger population were more comfortable disclosing a diagnosis of mental illness. However, within families and in the community, this becomes difficult as the older generation continue to feel 'shame' and expect these issues to be hidden from the community. This attitude reinforces to the younger generation the need to hide their mental illness from others.

> I feel comfortable talking about our mental health issues, but my mum will not. I have a relative who has a mental illness, but there is no forum to discuss this, at all. My mother says, 'Why are you throwing our ceeb (shame) out there'? (into the community)? And that's the thing I don't want (to bring shame to my family). Therefore, I think it is because of ceeb (shame) that we got to hide our (mental illness status). [FGD 1, Participant 3]

Mistrust of Australian healthcare systems

Mistrust in the Australian healthcare system came across strongly in the voices of participants. Most

participants spoke about the older generation Somalis' negative experiences in attempting to access health care. This was particularly related to them not trusting healthcare services and feeling that professionals would not understand their circumstances or culture This was further enhanced when it came to experiences with the Australian mental health care system. The women acknowledged that older generation community members mistrusted and were fearful of mental health professionals and this contributed to a reluctance to adhere to prescribed treatments.

> The community perception of you seeking help prevents you from seeking help because they will say, why are you seeing this cadaan (white) psychologist. They won't help you. They don't understand you, your culture, and your life. [FGD 4, Participant 3]
>
> Because (discussing mental health in Somali-Australian community) is taboo, and we don't really discuss the effects (or impacts) in our communities. It's more like Qur'an saar (read Qur'an on the person) or (the community will respond with), we'll pray for you. But sometimes it is a chemical imbalance or other reasons (than lack of faith, curse or jinn possession), and we don't really explore those options. [FGD 3, Participant 2]

Denial of mental illness

Mistrust of Australian healthcare systems contributed to the final theme of denial of mental illness. The participants identified that within the Somali-Australian community it was common for families to inform the community that their child had behavioural problems rather than the child experiencing mental illness. The participants expressed that it was a culturally acceptable practice to send the young person back to relatives in Somalia so they could learn to appreciate their privileged lifestyle in Australia and modify their behaviour.

> I feel like a lot of the kids that are taken back home (dhaqan ceelis), there might be something wrong (mental health issues), but people (parents and older generation) do not realise. [FGD 2, Participant 11]

The women in the study also acknowledged that when parents (older Somali generation) did seek professional help for mental illness for their child, often they would not be supportive of treatment due to feelings of mistrust.

> Sometimes (the community) will understand that there's something going on (more than jinn possession, curse or lack of faith) and obviously seek (medical) treatment for it. For example, your mum or dad will recognise there's something wrong (mentally unwell) with you and take you to see the doctor to explain what's happening. The doctor will prescribe you with some medicine, but your parents will say, no don't take that, it will make you crazy. [FGD 2, Participant 4]

DISCUSSION

The purpose of this descriptive qualitative study was to explore first-generation Somali-Australian women's understanding of mental health and illness, and to understand the women's perceived barriers to help-seeking for mental health problems. To an extent, mental illness is acknowledged within this community, however different diagnoses are perceived differently. For example, bipolar disorder and schizophrenia are viewed as a test from God, whereas anxiety and depression were commonly perceived as a punishment from God due to the individual's lack of faith or lack of adherence to religion practices. These negative perceptions and attitudes towards people with mental illness contribute to the stigmatization of mental illness within the communities (Ahmad *et al*. 2016).

The women in this study reported community shame surrounding mental illness and how this negatively impacts the individual with mental health issues and their family. Shame surrounding mental illness prevents individuals from seeking help, as they did not want to be labelled as someone who has weak faith and/or bring shame to their family. Therefore, the women felt that mental illness stigma could impact the person's future life choices particularly for seeking help or disclosing their diagnoses. Community stigma has been reported to negatively impact the individual's ability to obtain better employment opportunities, find suitable housing and is a barrier to help seeking (Corrigan 2004). To understand the impact stigma has on help-seeking, Clement *et al*. (2015) reviewed 144 studies conducted from 1980 to 2011. In this review, stigma was reported to be the highest ranked barrier to help-seeking in the general population and was found to have a moderate negative impact when compared with other barriers.

There are many misperceptions associated with mental illness that is present in the Somali-Australian community. The women described the causes and treatment of mental illness to be perceived differently within the Somali-Australian community when compared with the Western interpretation. In Western cultures, mental illness is thought to be caused by

biological factors (inherited genes and brain chemistry), medical factors, psychological factors, social factors (socioeconomic status, age, gender, migration, life events including trauma and culture) and drugs and alcohol misuse (Ellis *et al*. 2017). In the current study, the women discussed the Somali-Australian community belief that God and supernatural elements were causes of mental illness too. This observation strengthens Carroll's (2004) finding in which Somali refugees in New York identified three categories of mental illness: waali meaning crazy (trauma-related), murug meaning sadness (financial-related), and gini or jinn (possession of spirits) and its associated traditional remedies (family support, prayer, reading the Qur'an and traditional remedies). Other studies reported similar traditional remedies within the Somali community for emotional problems (Guerin *et al*. 2004; Wolf *et al*. 2016) in preference to modern Western treatments.

The women in the current study expressed that the older generation Somalis believed that God could cure mental illness through prayer and reading the Qur'an, however the women also advocated seeking medical assistance in conjunction with religious and traditional therapies. This belief in both traditional remedies and Western/medical treatment is important for clinicians to consider when providing care to members of the Somali-Australian community. Being able to access both remedies that accord with the cultural tradition in partnership with Western treatment would provide an indication that the service was trying to place importance on both culture and evidence. Migrant women experience many challenges when accessing healthcare services in Western countries but incorporating spiritual and traditional healing practices can be beneficial in promoting better mental health outcomes (O'Mahony & Donnelly 2007). Traditional healing practices such as reading the Qur'an, prayer and involving religious leaders are positive resources that should be involved in the provision of mental health services through partnerships, collaborations and community-based health systems (Satcher 2001). Marsella (2011) endorses this view, stating that community-based ethno-cultural services are an essential function in the delivery of mental health services. Previous studies have established that tailoring services to address cultural needs improves utilization and outcomes for minorities (Raguram *et al*. 2002; Satcher 2001).

Seeking treatment for mental health issues is discouraged and often feared by the older generation. Mistrust of the Australian healthcare system was identified as a help-seeking barrier in this study. This fear can be associated to community stigma and the general opinion that Western healthcare professionals are untrustworthy, unhelpful and will not address cultural needs (Rae 2014). The lack of trust between black patients and Western practitioners resonates across other studies (Abel & Efird 2013; Benkert el al. 2006; Boulware *et al*. 2003; Musa *et al*. 2009) as racial discriminatory treatment is a prevalent issue in healthcare. Previous studies have documented cultural mistrust of Western mental healthcare professionals and the mental health system by migrants and refugees' communities as a deterrent to help-seeking (Amri & Bemak 2013; McCann *et al*. 2016; Redmond *et al*. 2009).

Denial of a mental illness diagnosis in the Somali-Australian community was reported as a significant barrier to help-seeking. The women identified dhaqan celis, a cultural practice of sending relatives back to Somalia for those who behave in a socially unacceptable manner which includes having mental health problems or abusing drugs (Human Rights Watch 2015). There are two possible explanations for the continued practice of dhaqan celis. First, Somali cultural understanding of the mental illness diagnosis differs from the Australian understandings. This explanation relates to the Somali community view that mental illness is caused by demons, spirits and the evil eye, so they seek traditional remedies to treat the illness, which differs from the options available within the Australian healthcare system. Second, Somali migrants are still part of an extended family in their home country, so the extended family may take responsibility to help care for the individual (Tiilikainen 2011). Between the years 2005 and 2011, Tiilikainen conducted a six months ethnographic research focusing on the experiences of Somalis who were mentally ill and undergoing dhaqan celis in Somaliland. Regardless of the reason for the person being sent back for dhaqan celis, this practice provides hope that the person will be recover by strengthening their cultural, religion and family connections (Tiilikainen 2011). The practice of dhaqan celis, could be further compounded by the issues of cultural mistrust of the Western healthcare systems, lack of understanding, language barrier and fear of help-seeking due to shame and stigma.

Kleinsinger (2010) identified that the greater the cultural discrepancy between the patient (Somali) and the healthcare professional (European/Asian), the greater the likelihood for miscommunication and non-compliant behaviour of patient. Cultural differences impact how the patient understands the diagnosis, the causes, treatment and management plan (Kleinsinger

2010). Lack of cultural competency by mental healthcare professionals and services can negatively impact migrants help-seeking behaviour and thus contributing to the underutilization of mental health services (Bhui *et al*. 2007; McCann *et al*. 2016; Newbold 2005; Redmond *et al*. 2009; Whaley & Davis 2007). For these reasons, a cultural formulation interview was integrated into the in the DSM-IV to encourage clinicians to understand how cultural differences will impact their relationship with their clients (Ang 2017).

Cultural competency is the awareness, skills and processes that enable healthcare professionals to provide culturally appropriate services to their clients (Aggarwal *et al*. 2016). There is limited literature available on the relationship between cultural competency and evidence-based practice in mental health services for Somali-Australians. However, findings from Whaley and Davis (2007) suggest that adapting evidence-based treatments for people of colour could be efficacious. As cultural competency is a core requirement for mental healthcare professionals that work with CALD communities in America, Bhui *et al*. (2007) performed a systematic review evaluating cultural competency practice and service delivery. Out of potential 109 studies, only nine included an evaluation model to improve cultural competency and service delivery, with only one study demonstrating a positive change in attitudes and skills of staff following the training and no studies focused on user outcomes and experiences.

CONCLUSION

Our findings suggest that the Somali-Australian community would benefit from using traditional remedies combined with Western medicine when dealing with mental health problems. Therefore, the mental health outcomes for Somalis would improve if the mental healthcare professionals and services were able to work with the community to provide a treatment plan reflective of both views. Measures needed to promote help-seeking for mental health should include addressing the stigma and shame of mental illness, improving mental health literacy in the Somali-Australian community, increasing the cultural competency of mental healthcare professionals and promoting community involvement with the mental health services.

RELEVANCE FOR CLINICAL PRACTICE

Currently, there is little understanding on the factors that impact Somali-Australian women understanding about mental health and their perceived barriers to help-seeking. As an exploratory qualitative study, the findings of this study are limited to the participants and cannot be generalized. However, it does highlight the importance of understanding Somali mental health beliefs and practices, in order to create a culturally responsive program to promote utilization of the services and improve the community mental health outcomes.

REFERENCES

Abel, W. A. & Efird, J. T. (2013). The association between trust in health care providers and medication adherence among Black women with hypertension. *Frontiers in Public Health*, *1* (66), 2296–2565. https://doi.org/10.3389/fpubh.2013.00066.

Aggarwal, N. K., Cedeño, K., Guarnaccia, P., Kleinman, A. & Lewis-Fernández, R. (2016). The meanings of cultural competence in mental health: an exploratory focus group study with patients, clinicians, and administrators. *SpringerPlus*, *5*, 384. https://doi.org/10.1186/s40064-016-2037-4.

Ahmad, S. A., El-Jabali, A. & Salam, Y. (2016). Mental health and the Muslim word. *Journal of Community Medicine and Health Education*, *6* (3), https://doi.org/10.4172/2161-0711.1000445.

Amri, S. & Bemak, F. (2013). Mental Health Help-Seeking Behaviors of Muslim Immigrants in the United States: Overcoming Social Stigma and Cultural Mistrust. *Journal of Muslim Mental Health*, *7* (1), https://doi.org/10.3998/jmmh.10381607.0007.104.

Ang, W. (2017). Bridging culture and psychopathology in mental health care. *European Child & Adolescent Psychiatry*, *26*, 263–266. https://doi.org/10.1007/s00787-016-0922-6.

Australia Government. (n.d.). *Migration to Australia*. Available from https://info.australia.gov.au/information-and-services/immigration-and-visas/migration-to-australia

Australian Bureau of Statistics (2017). *Census reveals a fast changing, culturally diverse nation*. Available from https://www.abs.gov.au/ausstats/abs@.nsf/MediaRealesesByCatalogue/05DEE7DFCA9C2E00CA25814800090FB2?OpenDocument

Australian Bureau of Statistics. (2019). *National Health Survey: First Results, 2017–18 (No. 4364.0.55.001)*. Available from https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2017-18~Main%20Features~Mental%20and%20behavioural%20conditions~70

Australian Bureau of Statistics. (2020). *Migration, Australia, 2018–19 (No. 3412.0)*. Available from https://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/3412.0Main%20Features22018-19?opendocument&tabname=Summary&prodno=3412.0&issue=2018-19&num=&view=

Benkert, R., Peters, R. M., Clark, R. & Keves-Foster, K. (2006). Effects of perceived racism, cultural mistrust and trust in providers on satisfaction with care. *Journal of the National Medical Association*, *98* (9), 1532–1540.

Bhui, K., Warfa, N., Edonya, P., McKenzie, K. & Bhugra, D. (2007). Cultural competence in mental health care: a review of model evaluations. *BMC Health Services Research*, *7*, 15, https://doi.org/10.1186/1472-6963-7-15.

Boardman, F., Griffiths, F., Kokanovic, R., Potiriadis, M., Dowrick, C. & Gunn, J. (2011). Resilience as a response to the stigma of depression: A mixed methods analysis. *Journal of Affective Disorders*, *135*, 267–276. https://doi.org/10.1016/j.jad.2011.08.007.

Boulware, L. E., Cooper, L. A., Ratner, L. E., LaVeist, T. A. & Powe, N. R. (2003). Race and trust in the health care system. *Public Health Reports*, *118* (4), 358–365. https://doi.org/10.1093/phr/118.4.358.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3* (2), 77–101.

Carroll, J. K. (2004). Murug, Waali, and Gini: expressions of distress in refugees from Somalia. *Primary Care Companion to the Journal of Clinical Psychiatry*, *6* (3), 119–125. https://doi.org/10.4088/pcc.v06n0303.

Clement, S., Schauman, O., Graham, T. *et al*. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine*, *45* (1), 11–27. https://doi.org/10.1017/S0033291714000129.

Connor, P. & Krogstad, J. M. (2016). *5 facts about the global Somali diaspora*. Available from https://www.pewresearch.org/fact-tank/2016/06/01/5-facts-about-the-global-somali-diaspora/

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychological Association*, *59* (7), 614–625. https://doi.org/10.1037/0003-066X.59.7.614.

Corrigan, P. W. & Rao, D. (2012). On the self-stigma of mental illness: stages, disclosure, and strategies for change. *The Canadian Journal of Psychiatry*, *57* (8), 464–469. https://doi.org/10.1177/070674371205700804.

Corrigan, P. W. & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry*, *1* (1), 16–20.

Creswell, J. (2014). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*, 4th edn. Thousand Oaks, CA: Sage.

Ellis, P., Every-Palmer, S. & Einstein, A. (2017). What causes mental illness? In: S. Bloch, S. A. Green, A. Janca, P. B. Mitchell & M. Robertson (Eds). *Foundations of Clinical Psychiatry*, 4th edn. Melbourne: Melbourne University Publishing.

Guerin, B., Guerin, P., Diiriye, R. O. & Yates, S. (2004). Somali conceptions and concerning mental health: Some guidelines for mental health professionals. *New Zealand Journal of Psychology*, *33* (2), 59–67.

Human Rights Watch (2015). *Chained like prisoners*. Available from https://www.hrw.org/report/2015/10/25/chained-prisoners/abuses-against-people-psychosocial-disabilities-somaliland

Kirmayer, L. J., Narasiah, L., Munoz, M. *et al*. (2011). Common mental health problems in immigrants and refugees: general approach in primary care. *Canadian Medical Association Journal*, *183* (12), https://doi.org/10.1503/cmaj.090292.

Kleinsinger, F. (2010). Working with the noncompliant patient. *The Permanente*, *14* (1), 54–60. https://doi.org/10.7812/tpp/09-064.

Marsella, A. (2011). Twelve critical issues for mental health professionals working with ethno-culturally diverse populations. *Psychology International*, *22* (3), 7–10.

McCann, T. V., Mugavin, J., Renzaho, A. & Lubman, D. I. (2016). Sub-Saharan African migrant youths' help-seeking barriers and facilitators for mental health and substance use problems: A qualitative study. *BMC Psychiatry*, *16*, 2751–10. https://doi.org/10.1186/s12888-016-0984-5.

Merriam-Webster. (n.d.). *First-generation*. In the Merriam-Webster.com dictionary. Available from https://www.merriamwebster.com/dictionary/first-generation

Minas, H., Kakuma, R., Too, L. S. *et al*. (2013). Mental health research and evaluation in multicultural Australia: developing a culture of inclusion. *International Journal of Mental Health Systems*, *7* (1), 23. https://doi.org/10.1186/1752-4458-7-23.

Musa, D., Schulz, R., Harris, R., Silverman, M. & Thomas, S. B. (2009). Trust in the health care system and the use of preventive health services by older black and white adults. *American Journal of Public Health*, *99* (7), 1293–1299. https://doi.org/10.2105/AJPH.2007.123927.

Newbold, K. B. (2005). Health status and health care of immigrants in Canada: a longitudinal analysis. *Journal of Health Services Research & Policy*, *10* (2), 77–83. https://doi.org/10.1258/1355819053559074.

O'Donoghue, B., Downey, L., Eaton, S., Mifsud, N., Kirkbride, J. B. & McGorry, P. (2019). Risk of psychotic disorders in migrants to Australia. *Psychological Medicine*, 1–9, https://doi.org/10.1017/S0033291719004100.

O'Mahony, J. M. & Donnelly, T. T. (2007). The influence of culture on immigrant women's mental health care experiences from the perspectives of health care providers. *Issues in mental health nursing*, *28* (5), 453–471. https://doi.org/10.1080/01612840701344464.

Rae, S. (2014). *Somali male refugees: perceptions of depression and help-seeking*. [Doctoral dissertation, University of East London]. University of East London Research Repository. Available from https://repository.uel.ac.uk/item/85888

Raguram, R., Venkateswaran, A., Ramakrishna, J. & Weiss, M. G. (2002). Traditional community resources for mental health: a report of temple healing from India. *British Medical Journal*, *325* (7354), 38–40. https://doi.org/10.1136/bmj.325.7354.38.

Redmond, M. L., Galea, S. & Delva, J. (2009). Examining racial/ethnic minority treatment experiences with specialty behavioral health service providers. *Community Mental Health Journal*, *45*, 85–96. https://doi.org/10.1007/s10597-008-9164-5.

Satcher, D. (2001). *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of*

the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services. https://doi.org/10.13016/jelackxw.

Tiilikainen, M. (2011). Failed diaspora: experiences of dhaqan celis and mentally ill returnees in Somaliand. *Nordic Journal of African Studies*, *20* (1), 71–89.

Veysi, C., Zeliha, Ö.-E., Ürün, Ö. *et al*. (2017). Mental health problems of second generation children and adolescents with migration background. *International Journal of Psychiatry in Clinical Practice*, *21* (2), 142–147 https://doi.org/10.1080/13651501.2017.1291820.

Whaley, A. L. & Davis, K. E. (2007). Cultural competence and evidence-based practice in mental health services. *American Psychologist*, *62* (6), 563–574. https://doi.org/10.1037/0003-066X.62.6.563.

Wolf, K. M., Zoucha, R., McFarland, M., Salman, K. & Dagne, A. (2016). Somali immigrant perceptions of mental health and illness: an ethnonursing study. *Journal of Transcultural Nursing*, *27* (4), 349–358. https://doi.org/10.1177/1043659614550487.

World Health Organization. (2012). *A manual for checking: Mental health best practices in Somalia*. Available from http://www.emro.who.int/images/stories/somalia/documents/WHO_MHhandbook_LR_nov5.pdf

Worldwatch Institue (2018). *Somalis cope with triple disaster of drought, flooding and warfare*. Available from http://www.worldwatch.org/node/4813