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New Directions in Refugee Youth Mental Health Services: Overcoming Barriers to Engagement

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Mental health outcomes in refugee youth are diverse, ranging from prolonged difficulties to resiliency. Refugee communities rarely access services, even for those youth who are in need. Barriers include (a) distrust of authority and/or systems, (b) stigma of mental health services, (c) linguistic and cultural barriers, and (d) primacy and prioritization of resettlement stressors. Mental health promotion among refugee youth requires an integrated response to these barriers. This article includes a description of how the previously mentioned barriers may prevent refugee youth from receiving mental health services; approaches to addressing them; and a detailed description of Supporting the Health of Immigrant Families and Adolescents (Project SHIFA), a program developed in collaboration with the Somali community in Boston, Massachusetts.

Keywords refugee, treatment engagement, service access, trauma

The office of the United Nations High Commissioner for Refugees (UNHCR, 2009) currently reports that there are more than 12 million refugees and asylum seekers in the world. In the United States alone there are nearly a million refugees and asylum seekers (UNHCR, 2008, 2009), almost half of whom are younger than 18 years (UNHCR, 2009). By definition, refugee children and their families have been exposed to persecution and/or violence. In addition to past exposure to potentially traumatic events, refugee children and their families who have relocated to the United States are faced with stress associated with acculturation (Lustig et al., 2004; Pumariega, Rothe, & Pumariega, 2005).

The mental health trajectories of refugee youth are diverse, despite the significant stress and trauma that most have experienced. Studies have documented both significant mental health problems (Kinzie, Sack, Angell, Manson, & Rath, 1986; Rothe et al., 2002; Rothe, Castillo-Matos, & Busquets, 2002; Weine et al., 1995) and long-term trajectories marked by high functioning and resilience (Becker, Weine, Vojvoda, & McGlashan, 1999; Papadopoulos, 2001; Pumariega, Rothe, & Pumariega, 2005; Sack, Him, & Dickason, 1999; Watters, 2001). Given the diverse outcomes seen among refugee youth, questions regarding how secondary prevention and intervention programs can promote positive outcomes are paramount.

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At present, mental health services are likely a minor contributor to positive mental health among refugee youth for the simple fact that services are rarely accessed (Birman et al., 2005; Lustig et al., 2004). Children, particularly ethnic minority children, underutilize mental health services (Coard & Holden, 1998; Kataoka, Zhang, & Wells, 2002; Takeuchi, Bui, & Kim, 1993). Refugee and immigrant children access services less than nonimmigrant children (Huang, Yu, & Ledsky, 2006; Munroe-Blum, Boyle, Offord, & Kates, 1989). An estimated 92% of immigrants and refugees deemed in need of mental health services never receive them (Birman et al., 2005; Ellis et al., 2010; Kataoka et al., 2002). Poor access to services is likely the result of multiple barriers. In order to provide effective mental health promotion programs for refugee youth, strategies for engaging youth in treatment must be integral parts of any intervention program.

Although barriers to treatment engagement among refugees have not been well researched (Wong et al., 2006), practical experience of refugee providers and partnerships with refugee communities, as well as the extant research, have highlighted key barriers to youth receiving mental health care (Murphy, Ndegwa, Kanani, Rojas-Jaimes, & Webster, 2002; Tribe, 2002). These barriers include (a) distrust of authority and/or systems, (b) stigma of mental health services, (c) linguistic and cultural barriers, and (d) primacy and prioritization of resettlement stressors. Mental health promotion among refugee youth requires an integrated response to these barriers.

In this article we describe how the previously mentioned barriers may prevent refugee youth from receiving mental health services when they are in need. We then present approaches that address these barriers, as illustrated by different refugee youth intervention programs. Finally, we describe in detail a program developed in collaboration with the Somali community in Boston, Massachusetts, in response to these known challenges to intervention with refugee youth.

Barriers to Engagement in Mental Health Services

Distrust of Authority and/or Systems

Services for refugee youth must be developed mindful of the history and experience of refugees. The experience of refugees often includes extreme abuse of power by those in authority. Systems usually designed to protect people may have come under the power of those who perpetrated atrocities. Sharing personal information with strangers, such as one's tribal affiliation, may have placed one at risk of being a target of violence. Many refugee communities have developed a distrust of authorities and governmental systems, especially those who have experienced government-sanctioned persecution and violence (Daniel & Knudson, 1995; Lawrence & Kearns, 2005; Palmer, 2006; Scuglik, Alarcon, Lapeyre, Williams, & Logan, 2007), and this distrust may be applied to service systems. Power is also a central issue. Due to a history of being marginalized and a legacy of disempowerment in social, political, and economic arenas, there may be mistrust of service providers who represent a more socially empowered group (Hollifield, 2004; Hundley & Lambie, 2007; Scuglik et al., 2007). Issues of power and distrust may affect services at the individual level, challenging the development of a therapeutic alliance, or at a programmatic and community level. The potential legacy of distrust may require extra time for rapport building and development of a sense of safety and security during the process of treatment (Ehntholt & Yule, 2006; Hundley & Lambie, 2007; Nadeau & Measham, 2005). Programs need to identify ways to build trust with not only one child and family but the whole community.

Stigma of Mental Illness

The stigma of mental illness within many refugee communities may provide a barrier to seeking mental health services (Murphy et al., 2002; Osterman & de Jong, 2007; Palmer, 2006). In many cultures, mental illness is considered a taboo topic and is not openly discussed (Delgado, Jones, & Rohani, 2005; Scuglik et al., 2007). For some refugee groups, there may be limited words to describe mental health or illness in their language (Guerin, Guerin, Diiriye, & Yates, 2004; Kugler, 2009; Palmer, 2006). In some refugee communities resettling in the United States, mental illness is not understood on a continuum; an individual is either well or "crazy" (Guerin et al., 2004; Scuglik et al., 2007). Youth problems, when identified, are often framed as issues of cultural conflict within the family or difficulties with youth success at school. For example, a child who self-medicates with drugs due to mental health issues may be seen as "bad" and subsequently ostracized from the community. In some instances, community members may be concerned that if a child is known to be receiving mental health care, the stigma he or she may experience would be more damaging than receiving no care at all.

Language and Cultural Factors

When a family does seek to engage mental health services for a child, the lack of linguistic and culturally appropriate services presents a further barrier (Gong-Guy, Cravens, & Patterson, 1991; Guerin et al., 2004; Singh, McKay, & Singh, 1999; Wong et al., 2006). Linguistic and cultural competencies are related issues that we address separately.

To be accessible, services must be available in the language of fluency for both the child and parents. Although refugee youth rapidly develop English language skills, full proficiency takes approximately eight years, particularly for youth who have arrived with deficits in education or lack literacy in their native language (Collier, 1995). Other youth develop proficiency in but lack fluency in the native language spoken at home (Delgado et al., 2005). Even when a youth is fluent in English, parents often are not (Alvarez, 1999; Fang & Wark, 1998; Hou & Beiser, 2006), thus presenting a challenge to obtaining parental consent for treatment of a child and subsequently engaging the parents in the child's treatment. Given the range of linguistic proficiency among refugee youth and their parents—and at times the preference for different language between child and parent—services need to be flexibly available in different languages. Changing demographics of refugee arrivals further complicates the capacity of mental health service organizations to provide linguistically appropriate services.

A related challenge to accessing mental health service is the lack of culturally appropriate services available. As with language, what is culturally appropriate may vary depending on the community that is being served. Culturally appropriate practice requires having a basic fund of knowledge about the refugee group, such as their country of origin's history and their reasons for fleeing (Delgado et al., 2005; Ehntholt & Yule, 2006), along with an understanding of cultural norms and traditions (Osterman & de Jong, 2007; Schwab-Stone, Ruchkin, Vermeiren, & Leckman, 2001). It is also critical to know about culture-specific explanations of and expressions of mental illness. Families may hold different explanatory models for their children's problems (Kleinman, 1980; Weiss, 1997) and view what mental health providers may label as mental illness as problems related to spirits or religion (Kleinman, 1980; Palmer, 2006; Scuglik et al., 2007). Families with different explanatory models logically seek solutions other than mental health care and may view mental health services as irrelevant to the problem at hand. Mental health services that do not explicitly integrate cultural training and consultation into their practice, and models of

care that do not allow for flexible adaptation to different cultures, contribute to a lack of culturally appropriate services for refugee youth (as also noted by Arvidson, Kinniburgh, Howard, Spinazzola, & Blaustein, this issue).

Primacy of Resettlement Stressors

Finally, even if barriers of trust, stigma, and culture are addressed, many refugee families do not identify obtaining mental health services for their children as a primary need. Rather, managing the resettlement stressors, such as ensuring adequate food and housing for the family and securing employment are prioritized (Hess, Barr, & Hunt, 2009; Palmer, 2006). Murphy and colleagues (2002) argue that these basic needs must be met before refugees can focus on their mental health. Research also suggests that these ongoing stressors may be important determinants of a child's mental health and well-being (Ellis, MacDonald, Lincoln, & Cabral, 2008; Mann & Fazil, 2006; Miller et al., 2002). Despite this, mental health service systems and refugee resettlement services typically are delivered by different agencies and with relatively little connection. Families referred to mental health services may look to providers for assistance with tangible needs such as food and housing and be reluctant to spend time and energy engaging in services that do not address basic needs. Mental health services that continue to narrowly define the scope of care as an individual child's symptoms, rather than addressing other aspects of the social ecology that impact the child, are unlikely to engage refugee families that are struggling to manage significant stressors in their social environment.

Strategies for Addressing Barriers

In acknowledgment of a need for new approaches to engagement of immigrant and refugee youth and in accessing mental health services, programs have begun to address the barriers to serving refugee children and families in tangible ways. Programs developed specifically for refugee and immigrant youth often demonstrate innovative strategies for engaging families. Strategies that have shown particular promise include engaging the cultural community in the development of services (Measham, Rousseau, & Nadeau, 2005; Weine, Ware, & Klebic, 2004; Weine et al., 2005); locating mental health services within nonstigmatized service systems such as schools (Jaycox, 2004; Kataoka et al., 2003; Rousseau & Guzder, 2008; Stein); developing partnerships among providers, educators, and the community (Measham et al., 2005); and integrating services (Watters, 2001; Watters & Ingleby, 2004; see Figure 1).

Engaging Family and Community

Refugee families and communities are essential partners in developing mental health programs for their youth. Engagement of family and community serves to diminish power differentials between providers and clients and to develop trust. Collaborating with the community, building partnerships with key stakeholders, and including families in the development and oversight of programs in a substantive way both enhance the cultural appropriateness of the services and break down barriers related to distrust of authority. Parent outreach programs and community advisory boards provide means of ongoing connection and meaningful involvement of parents. Despite this, inclusion of refugees in the development of services is rare (Murphy et al., 2002; Watters, 2001; Watters & Ingleby, 2004). One model program was developed by Weine and colleagues (Weine

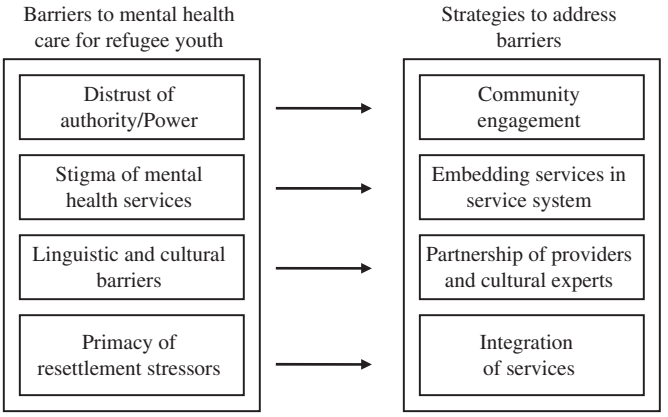

Figure 1. Identified barriers to mental health services for refugee youth and corresponding strategies for engagement of cultural communities in the development of services.

et al., 2005; Weine et al., 2004). They developed an innovative approach to involving the family and community through their Coffee and Family Enhancement Services (CAFES), Youth CAFES (Weine et al., 2006), and Tea and Family Education and Support (TAFES; Weine et al., 2003) programs. In these programs, family engagement strategies included encouragement, the use of "affirmative idioms" during recruitment, and identifying and problem-solving barriers to participation. In addition, these programs were located in the community and run by ethnically matched facilitators (Weine et al., 2005; Weine et al., 2003). Research on these programs has demonstrated that these strategies increase family engagement and access to mental health services (Weine et al., 2008).

Embedding Programs within Existing Service Systems

Locating services within service systems that are trusted and highly accessed by refugee families and youth, such as schools, is a powerful approach to diminishing the stigma associated with mental health services (Rousseau & Guzder, 2008). Identified problems such as school-related difficulties are typically more acceptable targets of services than problems defined as mental illness. Families often view children's education as highly valued and correspondingly view services associated with school success in a positive light. Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox, 2004) is a school-based intervention for youth aimed at the reduction of posttraumatic stress disorder (PTSD), depression, and anxiety due to trauma and exposure to violence (Layne et al., 2001). A modified version of CBITS, the Mental Health for Immigrant Program (MHIP; Stein et al., 2002; Stein, Kataoka, et al., 2003), has been developed to work with immigrant youth in the schools. Research has demonstrated that this program has been successful in the modest reduction of children's mental health symptoms (Kataoka et al., 2003). Thus, basing services within schools holds promise for reducing the stigma associated with mental health services and increasing engagement of refugee youth.

Partnerships of Providers and Cultural Experts

A variety of models have been used to address language and cultural barriers, including use of interpreters or cultural brokers. However, cultural appropriateness is not ensured

by having a cultural broker or interpreter present, as not all community members understand the range and diversity represented within a cultural group (Nadeau & Measham, 2005; Watters, 2001). Although it is difficult to delineate a specific approach that is culturally appropriate, a process of involving community voice and cultural experts in the development and provision of services helps to ensure that services are appropriate.

Partnering with community-based organizations that specialize in serving a refugee community and/or development of parent advisory boards help ensure that a diversity of perspectives from within a community is represented in the development and implementation of services. Researchers at Montreal Children's Hospital have developed a "transcultural psychiatry team," which includes psychologists, anthropologists, and community organizations working with refugees (Measham et al., 2005; Nadeau & Measham, 2005). This team provides culturally specific services and interventions for children, which include collective understandings of the child's mental health as well as inclusion of traditional healing ceremonies and interventions (Measham et al., 2005). The team has found that this has been a highly effective approach to engaging refugee families and reports that once a family attended the first appointment, 74% remained in treatment (Measham et al., 2005).

Programs that Provide a Range of Services

Integration of services can effectively address the barrier that families identify as resettlement stressors being the primary stressors on mental health, and by providing services that target stressors as well as mental health needs, family priorities are acknowledged. Benson (2004) showed that existing programs working with refugees typically use a comprehensive service approach to intervention, such as providing individual clinical work, family work, case management, community-based outreach, and coordinating systems of care for youth and families. In addition, addressing the various ongoing needs reinforces the relevance and program effectiveness for a family. Such comprehensive and integral care is exemplified by International Family, Adult, and Child Enhancement Services (FACES; Birman et al., 2008). FACES comprehensive care includes utilization of a multiethnic team-designed service and locates services within areas that are familiar and convenient to participants (Birman et al., 2008). This enables a shared responsibility, consultation with multiple providers, knowledge of potential services, and the consideration of culture among team members (Birman et al., 2008). Research has indicated that refugee children involved in FACES, a culturally appropriate and comprehensive mental health program, have demonstrated improvement in their day-to-day functioning over time (Birman et al., 2008).

The programs highlighted previously illustrate innovative ways of providing mental health services to refugee youth. In the following we detail one specific program that has been developed to directly address the barriers identified and that incorporates the four core strategies identified to address these barriers.

Program Example: Supporting the Health of Immigrant Families and Adolescents (Project SHIFA)

Project SHIFA is a school-based mental health promotion program for Somali youth based in a middle school within Boston Public Schools (Children's Hospital Center for Refugee Trauma and Resilience, 2010). Project SHIFA was developed in response to local data that showed that, despite significant levels of trauma exposure and posttraumatic stress

symptoms among Somali youth resettled in the Boston area, the vast majority of these youth were not seeking or receiving mental health services. Conversations with community leaders and an advisory board confirmed that youth adjustment and success was a key issue of concern and that culturally appropriate services that could support youth adjustment would be highly valued. Following a four-year period of partnership development and the collection of both qualitative and quantitative data that illustrated types of stressors, mental health problems, and attitudes toward healing and services within the Somali community, Project SHIFA was launched. Project SHIFA is currently in its third year of implementation and evaluation. The following is a description of the program as well as key elements of partnership development that underlie the program's success.

Framework for Engagement: The Community and the Service System. Project SHIFA is oriented around the gateway provider model of youth access to services (Stiffman, Pescosolido, & Cabassa, 2004). This model is built around the idea that youth often do not seek or access mental health services themselves (Burns & Costello, 1995; Saunders, Resnick, Hoberman, & Blum, 1994). Instead, they access "gateway providers" such as parents, teachers, or primary care physicians who can then refer them for the necessary mental health services (Stiffman et al., 2004). Thus, mental health services for youth with significant needs must be built on a much broader platform of community, service systems, and youth engagement that seek to educate and support both the youth and the gateway providers. Intervention services are provided to a subset of youth within the community, but successful engagement of these youth involves programming and involvement with youth, families, service systems such as schools, and the community more broadly. The broad community and the service systems are engaged at a level of psycho-education and outreach. Youth who are at-risk for the development of mental health problems are engaged through school-based groups. Finally, those youth that demonstrate significant mental health needs are engaged in Trauma Systems Therapy, an evidence-based mental health intervention that has been adapted for Somali culture. Each of these elements and the primary goals of providing these services are described in the following, as well as illustrated in Figure 2.

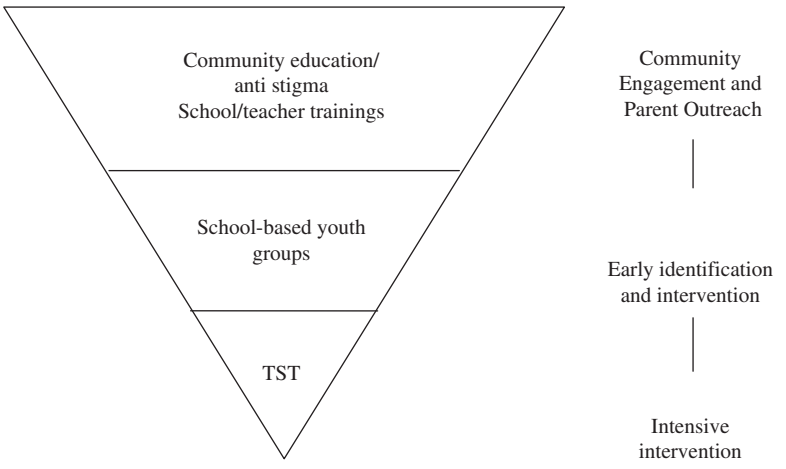

Figure 2. Project SHIFA's continuum of care and corresponding goals for the provision of services.

Engaging the Community: Outreach and Psycho-Education. The foundation of Project SHIFA rests on the active engagement of the broader Somali community. The primary goals of this element of the program are to (a) connect Project SHIFA staff with community members prior to the identification of a problem so that trust and familiarity are developed and (b) provide psycho-education to parents in order to engage them in a conversation of how mental health services (under Project SHIFA) can support their goals for their children. Community outreach is conducted under the leadership of a local community-based organization that has years of experience working with the Somali community and is staffed by Somalis. Psycho-education occurs in the context of social gatherings hosted by the organization, such as a Ramadan tea, or one-on-one conversations held in connection with other services (e.g., while an agency worker is helping a parent apply for benefits). A six-member parent advisory board meets regularly to review the program and discuss priority needs of community youth.

Additional parent outreach focuses on connecting parents of youth with their children's school. Because many of the youth receiving intervention services through Project SHIFA have been identified due to behavior problems at school, involvement of parents in the child's school is essential. However, frequently parents have little or no connection to their child's school. Within Somalia, matters of school success and behavior are understood to be the domain of the teachers, and parents intentionally do not interfere, just as in some other cultures (Birman & Espino, 2007; Chen, Kyle, & McIntyre, 2008; Sobel & Kugler, 2007). Thus, engaging with the school regarding child behavior is a cultural shift that must be learned. In addition, for some parents the prospect of navigating public transportation to reach their child's school and the linguistic barriers typically present provide added challenges to being a part of their child's school experience. In an effort to address this and bring parents and school staff into closer connection, Project SHIFA staff attend and encourage parents to attend school functions such as open houses. In one example of a particularly successful initiative, the school held a computer literacy training program for all school parents. Project SHIFA staff participated in the program, helping Somali parents with their learning while also engaging both parents and children in a positive interaction. By focusing on something concrete and useful to the families, SHIFA staff connected with families in a positive, nonstigmatized context.

Engaging the Service System: School-Based Groups and Staff Training/Consultation. As described previously, schools provide an important base for mental health interventions for refugee children. Children attend school and thus are easily engaged through schools, and research suggests a positive school experience may be an important determinant of mental health for refugee youth (Fazel & Stein, 2002; Kia-Keating & Ellis, 2007). Thus, under Project SHIFA, the school is both the *setting* for services and the *target* of intervention services.

In accordance with a public health model that targets secondary prevention toward youth at-risk for mental health problems, Project SHIFA provides weekly supportive groups for Somali youth in the English language learner (ELL) classrooms. Somali youth in these classrooms are typically at increased risk for mental health problems due to a history of trauma exposure, the ongoing stress of resettlement, and acculturative stress. Project SHIFA groups meet weekly, with approximately eight girls or boys per group. Groups are co-led by Somali and non-Somali Project SHIFA staff members, at least one of whom is clinically trained. The focus of the groups is two-fold: (a) addressing the stressors known to be associated with worse mental health among refugees such as acculturative stress (Ellis et al., 2008) and (b) increasing emotion regulation skills. In addition to providing

skills, the groups allow Project SHIFA staff to become familiar and supportive presences in the youths' school experience in a nonstigmatized setting. Project SHIFA staff are also in a unique position to observe youth and identify those who may benefit from a more intensive trauma-focused intervention.

Basing Project SHIFA within the school setting not only allows access to the youth but also allows for collaborative work within the school to develop an environment that maximally supports refugee youth. Project SHIFA's involvement with the school system ranges from broad-based trainings in culture and trauma to individual consultation with teachers around the role of trauma in refugee youth classroom behavior and successful strategies for managing traumatic responses within the classroom setting. As an example of an approach to intervening with the broader school culture, when interethnic group tension was identified, Project SHIFA staff and key classroom teachers held a school dance during which students from the different ethnic groups had a chance to socialize in a monitored social setting. Tension was anecdotally noted to diminish significantly in the wake of this intervention.

Engaging Youth with Significant Mental Health Needs: Trauma Systems Therapy. Although some Somali youth adjust well and are sufficiently supported through the groups, a subset of youth demonstrate significant trauma-related mental health needs. These youth receive services under the Trauma Systems Therapy (TST) model (Saxe, Ellis, & Kaplow, 2006). TST is a multidisciplinary treatment approach that focuses on integrating services by addressing the "trauma system." The trauma system is defined as a traumatized child who is experiencing emotional dysregulation and a social environment that does not sufficiently support the child's ability to regulate emotions. TST is based on a social ecological model that places a child's development and functioning within the context of the social environment and provides interventions that focus on both stressors within the social environment that trigger a child's dysregulation and interventions that bolster a child's emotion regulation skills. This intervention is particularly apt for refugee youth who typically (a) have experienced significant trauma and (b) are experiencing significant resettlement and acculturative stressors.

Under TST, an assessment is done of both the child's social environment (designated as stable, distressed, or threatening) and the current emotional dysregulation (emotionally regulated, emotionally dysregulated, or behaviorally dysregulated). Different phases of treatment are identified for youth depending on the assessment of the social environment and emotion regulation. Children assessed to be behaviorally dysregulated and in a threatening social environment receive the most intensive interventions (in what is called a "surviving" phase of treatment). Treatment phases are correspondingly less intensive as the social environment becomes more stable and/or the child's regulation improves.

Services under TST include school-based, skill-based individual psychotherapy; home-based care; services advocacy; and, as needed, psychopharmacology. Although not all children require all types of services, those who are in earlier phases of treatment (e.g., with a high degree of emotional or behavioral dysregulation and instability within the social environment) typically benefit from multiple services provided in an integrated manner. The main focus of the different services is briefly described in the following.

Individual skill-based psychotherapy typically begins with a focus on emotion regulation skill building. Within the Somali language relatively few words are available to label emotions, so additional skill building related to identifying and labeling emotions is included. As youth develop better regulation skills and as their social environment stabilizes, they move into a cognitive processing phase of treatment, followed by meaning making.

Home-based care is provided through a partnership between home-based clinicians and a cultural broker. Home-based treatment typically focuses on stabilizing the social environment and may include addressing resettlement stressors and family conflict (often related to acculturation differences of child and family). This element of TST helps to address some of the concrete stressors that families often identify as priorities and greatly facilitates family involvement and engagement. Cultural brokering is an essential part of this service; cultural brokers approach each family's situation uniquely, providing psycho-education about mental health and assistance in negotiating service systems.

Services advocacy involves skilled advocacy for children who face structural stressors such as involvement with the court system, inappropriate school placement, or inadequate housing. In situations where these structural problems are deemed to be directly contributing to a child's dysregulation (e.g., are part of the trauma system), clinicians or cultural brokers engage in advocacy, aided by consultation with lawyers when needed to address and change these systemic problems. For refugees for whom rights and benefits frequently are not in place, or who have difficulty navigating the complex benefits systems, this service can make significant structural changes in their lives and directly contribute to mental health promotion of youth.

Finally, for some youth, psychopharmacology is helpful in managing more severe emotional dysregulation. Within the Somali community, medication is typically seen as undesirable and treated as a last resort. Notably, within Project SHIFA, most youth (even those with significant dysregulation) have been able to become stable without medication once the significant social stressors were targeted and diminished and with culturally informed skill-based psychotherapy.

Foundational Aspects of Project SHIFA: Partnerships and Culture

As important as the content of Project SHIFA is the process by which it was developed and implemented. Project SHIFA is based on partnerships among mental health providers, educators, and community members. A leadership team composed of members of each of the partnering agencies meets monthly to review and guide the project. The roles of each of these groups are described briefly.

Mental Health Providers. A psychiatry department of a children's hospital provides the project leadership and clinical oversight. All mental health services are held to high clinical and ethical standards and delivered with fidelity under the specific TST treatment model. Staff members implement a rigorous evaluation of the program to establish effectiveness and contribute to program improvements as needed. The partnership also includes mental health providers currently placed in the school system and an agency that specializes in home-based care, so that other providers in the school and community receive training in the same treatment model and cross-referrals between teams can be made.

Educators. As described, school administrators and teachers are highly involved in Project SHIFA and are central to creating a school environment that maximally supports refugee youth. Within the middle school where the program is based, support of the principal, teachers, and student support staff are critically important to the success of the program. Provision of time and space for student meetings (both group and individual) is essential. Less tangible, but even more important, creating a culture in which mental health is seen as contributing to academic success is also essential.

A second level of partnership with educators is with a local graduate social work school, Boston University School of Social Work (BUSSW). BUSSW provides support for cultural competence within the work force through (a) placing interns with Project SHIFA and (b) supporting the training of Somali social workers through both mentorship and financial scholarships.

Community. Community members have partnered in Project SHIFA from its inception. A Somali-led community-based organization (Refugee and Immigrant Assistance Center) partners with the project and provides community outreach. In addition, a parent advisory board meets on a regular basis to oversee and inform program development and implementation. Finally, the intervention itself is carried out in part by two Somali interns who are being trained as social workers.

Integration of Services and Partners. With multiple agencies, disciplines, and cultures involved in Project SHIFA, communication between and among the team is essential. Weekly TST clinical team meetings provide a forum for ensuring that services are integrated and oriented around a common treatment plan. Both cultural experts and clinical experts (and some members who are both) are regular members of the weekly team meeting. As individual cases are reviewed, challenges and possible approaches are reviewed from both a clinical perspective and a cultural perspective. Within the team, a high degree of respect for different viewpoints allows for open discussion of how to resolve potential differences between cultural and clinical perspectives and needs. The potential difficulty of managing both these perspectives is illustrated by a situation in which cultural norms dictate that a previously abusive husband be accepted back into the home by his wife. In this case, this risk of the family being alienated from the community by objecting to cultural norms and recommendations from an elder council must be weighed against the potential risks associated with a former abuser reentering a home. In a world of no easy answers, the regular face-to-face communication of the clinical and cultural team is essential to making sure the team's recommendations and approaches are mindful of the full range of risk and possibility.

Providing mental health services to refugee youth requires innovation in the face of barriers to engagement. Differing explanatory models, culture, language, stigma, and distrust of authority all present challenges to engagement that, if not addressed, will continue to lead to poor access to mental health care among refugee youth. Models from the field have begun to illustrate how these barriers can be overcome. In this article we have highlighted one specific model, Project SHIFA. This model provides one example of how multiple strategies for overcoming barriers can be infused into a program.

Project SHIFA Strategies for Overcoming Barriers to Care. Stigma is addressed through basing the program within schools, providing psycho-education broadly within the community, and ensuring that families and youth initially have contact with the program *before* significant mental health needs are identified. Supportive school-based groups for Somali youth have played an important role in decreasing the stigma of the program. Because all Somali youth from the ELL classrooms are invited to attend, groups do not single out youth with particular needs. Initial contact with both families and youth by Project SHIFA staff is in relation to the group and typically viewed as supportive. Once parental and child relationships with SHIFA clinicians are established in the context of the group, a foundation of trust is developed that allows a referral to individual services to be seen as simply another step on a continuum of help and support.

The establishment of trusting relationships with SHIFA staff in the context of supportive groups also serves to overcome barriers associated with distrust of authorities. This barrier is further addressed through the partnerships with Somali community-based organizations, which often are trusted sources of knowledge and leadership within the community. Finally, involvement of parents and other community members through an advisory board ensures that parents are deeply aware of the program goals and are themselves in positions of some authority within the program.

Culture and language are addressed through the development of an intercultural team. Cultural brokers and community leaders are integrated into all aspects of the program. In addition, a partnership with a local graduate school of social work has led to the training of two Somali social workers; thus, clinical care is provided either by or with input from a member of the cultural group, and cultural expertise, as represented by several members of the cultural group, is integrated into all clinical team meetings.

Finally, although Project SHIFA is a mental health intervention program for Somali youth, the provision of mental health services is embedded in a much broader system of support in relation to known resettlement stressors. Within the intervention model, TST social environmental stressors are addressed as core parts of the clinical intervention. Thus, case management to address stressors such as inadequate access to food is not seen as an ancillary need but as potentially a direct intervention that can reduce stress and related emotional dysregulation of a child.

Preliminary Findings: Engagement as a Process. Overall, preliminary data from the first 2 years of program implementation suggest that our program is highly successful in engaging youth in services. At the beginning of each school year, all Somali families with a child enrolled in the ELL program were contacted by a cultural broker from our program. The parents were told about Project SHIFA's presence in the school and encouraged to ask questions or contact us with any future questions or concerns. Consent for children to participate in the school-based groups was requested during this visit and 100% of families consented to have their child participate in the groups ($N = 30$). During the course of the school year 67% ($n = 20$) of the youth who were participating in the groups were identified as needing individualized mental health treatment. These families were again contacted and consent to treat their child in the school setting was requested and 100% ($n = 20$) of these families consented to have their child receive individual psychotherapy.

Under the TST model, clients who are experiencing a greater degree of distress typically receive home-based care in addition to skill-building psychotherapy. Of the 20 clients receiving individual psychotherapy, 7 (35%) were in sufficient distress to warrant home-based care (e.g., the family was about to face eviction, the child was at risk of being arrested). Cultural brokers identified that four of these families were likely to accept referrals for home-based care based on (a) the families themselves identified that there was an urgent need and (b) sufficient understanding of and acceptance of mental health services as a source of help. These four families were referred for home-based care and engaged. Three additional families who might have benefited from these services were not referred because cultural brokers felt that additional groundwork needed to be laid before families would accept and engage. In these cases, opportunities for engagement are monitored: When a crisis arises, families are frequently more open to trying new services, and referrals for home-based care are introduced accordingly. This illustrates an important principle of engagement, which is to approach engagement as a process rather than an end point. Within Project SHIFA, the process begins with engagement in a nonstigmatized

supportive group and additional levels of treatment and consent are sought as families develop greater trust and awareness of the services and service providers and as more urgent need arises.

Challenges and Limitations to the Model. Although Project SHIFA illustrates one way that barriers can be addressed in developing an intervention program for refugee youth, much work remains to be done. First, this model has been developed in close collaboration with the Somali community and in keeping with data specifically gathered from Somali youth in the Boston community. Applying this model to other refugee youth may require adaptation. Importantly, the process of developing the model, such as establishing partnerships, is likely to be common across other cultural groups, and many of the principles of the program may be transferrable. Second, while this model is being evaluated, we do not yet have data on how effective it is and in particular whether it is more effective than other models of care. A final challenge is that of sustainability. One of the strengths of Project SHIFA lies in its integration of multiple services. However, this also presents challenges to building a model of sustainability. For instance, although some elements of the clinical service may be reimbursed through third-party payments (e.g., skill-based psychotherapy and home-based intervention), cultural brokering that is sometimes paired with these services may not be reimbursable. In addition, much of the engagement services, such as community outreach and school-based groups, are not reimbursable under standard billing mechanisms. As innovative models are developed in response to the complex needs of refugee youth, the field will also need to engage policy makers in order to allow for sustainable models of care.

Given the high degree of trauma experienced by many child and adolescent refugees, programs that promote mental health are essential. At present the mental health service system falls short of offering the kind of comprehensive, culturally competent, systems-integrated care that can effectively engage refugee youth in services. Models from the field are beginning to emerge that provide innovative responses to the complex needs of refugee youth. Additional models that directly address issues of engagement and support for the evaluation of models that have already been developed will be critical to furthering the field of refugee youth mental health.

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