

Somali Mental Health Needs Assessment

Dakota County Public Health Department

Background:

In April 2016, Dakota County Public Health staff attended a women's interfaith meeting at the Islamic Institute of Minnesota in Burnsville, where the Burnsville mayor and a Burnsville police officer spoke to approximately 40 women, half of whom were Somali, about preventing youth from being radicalized. Dakota County Public Health staff was asked to return to speak with the women about adolescent risk-taking behaviors. Staff also spoke with nine mothers later that month at Dar-Us-Salam, an Islamic mosque, community center and school, also in Burnsville. The focus was on understanding the signs and symptoms of depression and anxiety in children and adults. All of these women had at least one child living with autism. Several parenting issues were raised at these meetings: discipline, child protection, autism, immunizations, mental health and mental illness, internet and phone safety, typical child/teen development, identifying emerging issues, and U.S. parenting norms and expectations. Dakota County Public Health staff consulted with Dakota County Social Services and several Somali mental health practitioners in the community to determine how to best support the concerns raised by the Somali women/mothers.

Purpose:

The purpose of conducting this needs assessment was to:

- 1) Understand the Somali cultural beliefs (strengths and challenges) which impact mental health and mental illnesses.
- 2) Understand how providers, schools, and communities can develop safe and trusting relationships with Somali families.
- 3) Understand mental health from a cultural perspective, i.e. stigma, fear, access to care, access to culturally competent providers, etc.
- 4) Learn how providers, schools, and communities can increase their cultural competency on how mental health and mental illnesses impact Somali individuals and families.
- 5) Learn how providers, schools, and communities can help preserve Somali cultural values and practices.

Methodology:

Nine interviews were conducted by Shannon Bailey, Mental Health Promotion Coordinator for Dakota County Public Health, throughout August 2016 with Somali leaders living and/or working in Dakota County, using a standard questionnaire (see Appendix A for questionnaire). The interviewer documented the interviewee responses by hand and emailed them to the interviewee following the interview for verification and correction (see Appendix B for list of interview participants).

Results:

The interview responses were categorized into six main themes: responsiveness to needs, service effectiveness, community engagement, culture, knowledge about the community, and education. Below are descriptions of the six main themes, broken out by subthemes that are illustrated with examples. The word-for-word responses are available by request.

Responsiveness to Needs

Below are themes that grouped around how Dakota County staff and community providers can better respond to the needs of the Somali community, related to mental health. These themes apply to both community-based interventions and individual direct service.

- **Youth engagement:** develop community-based youth diversion programs for first-time offenders; expand Somali-specific services for youth to support positive social connections (including youth mentoring programs, structured after-school opportunities, physical activities); invest resources in supporting younger children
- **Training opportunities:** offer Somali clients culturally-sensitive opportunities to increase skills on mindfulness, relaxation, and sense of acceptance; replicate the Fairview pilot program (Imam mental health training series) two-day training with monthly meetings for a year; Imams and co-facilitators were paid to participate
- **Service provision:** establish contracts with Somali providers; identify needs first and then provide a description of services (including expanded therapeutic options, home-based services); bring services and resources to the people (mosques and neighborhoods)
- **Specific therapy considerations:** utilize the harm reduction model; use a holistic approach; incorporate traditional healing practices into therapy; incorporate

client's beliefs into the goals and treatment plan; focus on solving daily stressors rather than typical cognitive behavior therapy; rationalize moving past traumatic events; help people to recognize and preserve the survival identities; provide solutions they can use to help themselves

Service Effectiveness

Several responses identified actions that Dakota County staff and community providers can take to be more effective in providing culturally sensitive services to the Somali community.

- **Customer service:** demonstrate good intentions to prevent people from being offended; offer a sincere approach with no strings attached; facilitate a warm hand-off to mental health providers; appropriately triage clients based on urgency of issue
- **Staff diversity:** hire employees who reflect the people served (Somalis are more comfortable interacting with other Somalis when requesting services); learn from surrounding counties
- **Cultural sensitivity:** ensure that interpreters are properly credentialed, culturally-specific, and understand the Dakota County policies and practices; translate all documents and local resources in print and online and ensure they are culturally-specific; ensure policies and practices are culturally-sensitive; provide staff with cultural training and make a commitment to continuing education; demonstrate interest in the client's culture and beliefs; remember that one person does not represent an entire culture; understand the history and culture of those you serve
 - **Somali-specific considerations:** educate employees on Islamic values and practices (including daily prayer practices and the role of the Imams), post-traumatic stress disorder, and Somali history and culture; understand the Islamic beliefs related to mental health; understand the cultural trauma that exists even among those born in the U.S.; ask clients which Islamic practices they use; study the underlying issues which contribute to the high rate of autism in Somali children; recognize "Somali time" - do not drop clients because of late or missed appointments
- **Policy and procedures:** clearly explain HIPAA and privacy laws; get more reimbursable services

Community Engagement

Below are themes that describe how Dakota County staff and community providers can effectively engage with the Somali community.

- **Relationship building:** clarify long-term goals and vision and plan to stay engaged long-term; build strong relationships; ask a lot of questions; establish trust; assume good intentions; always start with listening sessions/dialogues; clarify the purpose of meeting and what you can offer to the community; convey sincerity
- **Work with mosques:** go to the mosques and community centers to meet people, develop relationships, and educate people; outreach to Imams; do not hold community events at churches; engage with mosque leaders for presentations and always have them approve plans
- **Champions:** Mothers are the point people in the community, so work with women to make the greatest impact; identify existing champions
- **Community leading:** keep an open mind; understand customs; begin by addressing their concerns before discussing your agenda items; tell them how they will benefit from talking or meeting with you; allow them to ask questions and pique their curiosity; help people frame their issues; remember you are not the first person to ask Somali people the same questions

Knowledge about the Community

These themes explain key knowledge and trends about the Somali community.

- **Fears/trauma:** parents fear entrapment by the FBI because of past criminal investigations; there are some fraudulent community centers in Minneapolis, so there is distrust of services and providers, ex. new funds to prevent radicalization; parents fear children attending events located in churches, ex. schools requiring students to go to the local church during an emergency drill; parents fear losing their children to government and that they will be brainwashed about religion and culture; some people deny traumatic experiences
- **Youth use of time:** Somali youth do not have many structured after-school activities; adolescent rebellion is due to having too much unstructured time; widowed mothers (due to the deaths of fathers from war) often work more than one job so they may have to leave young people at home alone; these mothers are exhausted and not always emotionally available to their children; children spend

a lot of time in day care every day and lack opportunities to be physically active which may result in behavior concerns; parents value education and often enroll their children in after-school tutoring and Saturday religion classes; young people experience academic pressure; youth lack mainstream education and experiences

- **Providers and services:** people experience language barriers with providers; interpreters should serve clients of the same gender; many Somalis prefer to work with white female providers, but others feel that a white provider cannot relate to them; there are many more Somali professionals now compared to ten years ago
- **Demographics/socioeconomic status:** acquiring higher education, owning businesses, and increasing buying power are important to Somali people; many Somali people have achieved academic success and hold professional positions; many Somali people are financially stable
- **Health:** autism rates for Somali children are similar to white children, but Somali children have higher rates of severe forms

Education

These themes relate to how to educate Somali community members about mental illness/mental health and the services available to them.

- **Mental illness/mental health:** clarify that fight or flight was a survival mechanism in Somalia that can hinder functioning in the U.S.; communicate that you need to be as mentally healthy as possible to survive in this environment; focus on how accessing care will improve the person's functioning at work and at school; agree that they will die (pre-determined destiny), however new skills can improve quality of life now; educate people about the continuum of mental health and illnesses, because Somali people are just learning about mental health and mental illnesses; mental illnesses related to trauma, poor attachments, and personality disorders are viewed as behavioral issues which would not be appropriate for treatment; provide messages that it is ok to seek help for mental illnesses; always address the fear about immunizations and autism; keep repeating safety messages related to immunizations
- **Services:** Clarify local resources available, to what degree, and how much they cost; clearly explain what services you can provide

Culture

These themes address a variety of aspects of Somali and Muslim culture that may impact their approach to mental illness and mental health.

- **Religious values/faith:** Muslims are a strong, faith-centered community that follows the *Creed of God*; Muslims believe in Allah's will, that he is greater than all; Muslims believe in spirits (Jinn) that can possess a person; Islamic beliefs and God's will are very strong protective factors; you will be rewarded for charity; the Quran blesses people with deep spiritual attention; deep breathing cultivates innate Islamic practices; prayers can help distract a person who experiences ruminating thoughts; Islam is based on the Old Testament and "the tests" which include wealth, time, youthful age, and health; older Somalis tend to be more religious, but U.S. born Somali youth are holding onto their faith
- **Male roles:** Somali fathers are the disciplinarians and role models for boys; they may use harsh practices on boys; boys carry their father's standing and they assume the role of the father when their father/uncles have died; males are expected to work to meet the family's basic needs
- **Female roles:** females are expected to take care of the family and do not work unless there is no male in the household, but they are supported to acquire higher education; families will pay for a daughter's college expenses which are seen as an investment in the family; girls are expected to cover themselves because they are seen as having value; they hold the family's reputation and can bring shame on the entire family; girls do not leave the family until they start their own family; mothers are the number one point person in the community
- **Family:** the community has a duty to protect vulnerable people; intergenerational dependence is common as the community cares for its elders and does not abandon them; in Africa, the extended family lives together or within a very short distance which supports strong emotional attachments for children; the civil war caused extended family members to flee in different directions, contributing to post-traumatic stress disorder, depression and poor emotional bonding among children; parents fear being seen as incompetent; their children's misbehavior is a judgment against the family; family and friends have greater influence than professionals, including physicians; family values are stronger than religious values
- **Youth:** Islam educates all young people on moral values (right and wrong) beginning at age seven; many Somali boys lack a male role model and disciplinarian, because their fathers were killed in the war; boys do not always

respect their mothers and this disrespect may also be exhibited by other boys in the community; youth are accessing bad ideas online; young people get the message that no one in the U.S. cares about them; they do not see a path for the future; survival in the lawlessness in Africa depended on being strong (sometimes violent) which may now contribute to boys' acting out behaviors

- **Community ties:** Islam teaches strong faith and strong community bonds, never violence; everyone knows each other; common shared experiences are an equalizer for Somalis across socioeconomic status; there are broad tribal connections; people talk openly about their experiences, ex. war, camps; Somalis come from an oral culture, so there is no such thing as privacy; children are held accountable by the entire community - neighbors tell their parents everything; people extend themselves to support one another; young people are taught that community members will take care of them and treat them like family; Somali community provides a sense of security; offenses are solved between families; prisons are only for political defiance or terrorism; schools in Somalia use corporal punishment
- **Resilience:** Somali communities are resilient; Somali people welcome any help that is available; Somali people did not have a written language, but here, in order to be self-sufficient, they must learn to speak, read and write English; in the U.S., "they must be on top of their game to survive"
- **Mental illness:** there is stigma about mental illness; people with mental illnesses are outcasts from the community; stigma is shared across the culture leads to misunderstandings; Islam eliminates the risk of suicide; mental illnesses are not considered a curse or bad luck, but may be the result of prior actions; there is a very narrow definition of mental illnesses that refers to severe mental illnesses (waan - crazy) with no in-between, but this is changing; people often wait too long with symptoms before seeking help; untreated trauma helps them hide their symptoms; learning English is a source of great anxiety and other mental health challenges
- **Health/medicine:** Somali clients fear the interpreter will talk down to them and judge them; parents' fears about immunizations can expand to most of Western medicine and providers; Somalis understand physical pain and manifestations of stress; the Quran is used as a healing tool more often than medicine; Somalis do not have experience with treatment/therapy; Muslims prefer going to the mosque rather than to treatment or therapy, which is considered a weakness; Muslims believe that each person has a religious obligation to take care of themselves

Culturally Specific Recommendations

Responsiveness to Needs

- Practice active listening skills to identify client needs first and then provide a description of services
- Deliver services and resources to Somali people in mosques and in their neighborhoods
- Clearly explain HIPAA and privacy laws to ease fears related to utilizing services
- Establish Dakota County contracts with Somali providers in order to offer culturally competent services locally
- Develop community-based Somali youth diversion programs for first-time offenders
- Expand Somali-specific services for youth to support positive social connections (including youth mentoring programs, structured after-school opportunities, and physical activity opportunities)
- Invest in resources to support Somali children
- Replicate the Fairview Imam pilot mental health training program
- Research the underlying issues which contribute to the high rate of autism in Somali children
- Keep repeating safety messages related to immunizations

Therapy Specific Responsiveness

- Utilize the harm reduction model and a holistic approach
- Incorporate traditional Somali healing practices into therapy
- Incorporate the client's cultural beliefs into the goals and treatment plan
- Focus on solving daily stressors rather than using typical cognitive behavior therapy
- Help people to recognize and preserve their strong survival identities
- Agree that all people will die (pre-determined destiny) but skills can improve their well-being now
- Educate about the continuum of mental health, well-being, resilience and mental illnesses
- Educate about the biology of brain disorders and the impact of trauma on mental health
- Address stigma and promote help-seeking skills

Service Effectiveness

- Hire employees who represent the people served
- Ensure policies and practices are culturally-sensitive

- Provide employees with cultural training and require ongoing staff continuing education
- Offer a sincere approach with no strings attached, articulate good and sincere intentions
- Demonstrate interest in the client’s culture and beliefs
- Facilitate a warm hand-off to mental health providers
- Ensure that interpreters are properly credentialed, culturally-specific, and understand the Dakota County policies and practices
- Utilize same gender interpreters
- Translate documents and local resources in print and online as needed and ensure they are culturally-specific
- Recognize “Somali time” – do not drop clients because of late or missed appointments
- Educate employees on Islamic values and practices:
 - Daily prayer practices and the role of the Imams
 - Somali history and culture
 - Islamic beliefs related to mental health
 - Deep breathing cultivates innate Islamic practices

Community Engagement

- Always begin with authentic listening sessions and dialogues
- Build strong and trusting relationships by asking a lot of questions
- Meet with people in the mosques and at the Somali community centers
- Develop relationships with local Imams; get their approval before embarking on work plans
- Work with women and identify existing champions to make the greatest impact
- Begin by addressing the participant’s concerns before discussing your agenda items
- Allow participants to ask questions and pique their curiosity
- Remember you are not the first person to ask Somali people the same questions
- Explain how the participants will benefit from meeting or working with you
- Clarify the purpose of meetings and what you can offer the community
- Determine joint long-term goals and vision and commit to be engaged for the long-term
- Do not hold community events at churches

Action Steps to Increase Cultural Responsiveness

- ✓ Convene authentic dialogues to select the recommendations you or your organization will address
- ✓ Continue to build knowledge of the Somali community through collaboration, reading current research and best practices, and seeking additional input as needed.
- ✓ Develop a detailed work plan for incorporating top recommendations into your setting
- ✓ Implement recommended changes and document lessons learned
- ✓ Learn more, participate in professional development, and attend community gatherings
- ✓ Report action steps and outcomes publically online, in annual reports, in newsletters, and with Somali community members
- ✓ Review recommendations and update work plans annually

*The Recommendations and Action Steps sections provide guidance to Dakota County government staff as well as partners across disciplines, ex. schools, health care providers, law enforcement, and community services providers.

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Appendix A

Interview Questions

1. What things are essential in order to begin safe conversations about mental illnesses in the Somali community?
2. Describe the cultural strengths which promote positive mental health.
3. Describe the cultural challenges which impact positive mental health.
4. How can providers increase their cultural competency on mental illnesses?
5. How can providers help preserve cultural values, worldviews, and religious healing practices?
6. How do cultural beliefs impact willingness to learn about mental illnesses and accessing care/treatment?
7. How can Dakota County Social Services and the Public Health Department improve how they support families?
8. Is there someone else in the community I should talk with to gather more perspective?

Appendix B

Interviewees

Mohamed Abu, BS

Dakota County
Employment and Economic Assistance
Financial Assistant Specialist II

Asma Bulale, MPH

Somali American Parent Association
Community Engagement Specialist

Joel Friesen, MA, LMFT

Associated Clinic of Psychology
Assistant Director, Somali Services

Ahmed Hassan, MA, LPCC

Summit Guidance Center
Co-Founder, Program Director, Psychotherapist

Amin Mohamed, MPH

HealthPartners
Public Health Programs Manager

Mahsin Muhumed, MBA

Dakota County
Employment and Economic Assistance
Financial Assistant Specialist

Qudbi Dayyib (Q) Mursal

Dar-Us-Salam Mosque and Cultural Center
Principal and Volunteer Coordinator

Yussuf Shafie, MSW, LGSW

Alliance Wellness Center
Founder, Executive Director

Bisharo Yussuf, MA

Watercourse Counseling Center
Psychotherapist