MDH Minnesota Department of Health

CENTER FOR HEALTH EQUITY

Somali Mental Health Project Findings and Recommendations

Background:

In the 2014 Session, the Minnesota Legislature funded $501,000 in health equity grants, including funds for a conference focused on mental health in immigrant and refugee communities (Minnesota Laws 2014, chapter 312, art. 30, sec. 3, subd. 2).

As a result of this funding, in 2015, the Minnesota Department of Health (MDH) partnered with the Somali American Parent Association (SAPA) to organize a series of community dialogues about mental health attitudes, knowledge, perceptions, and gaps in services with Somali community members and service providers. In addition, SAPA hosted the first East African Mental Health Conference in the fall of 2015 to share current research and promising practices about adult mental health in the Somali community and other East African communities.

MDH Center for Health Equity Director ThaoMee Xiong and Somali American Parent Association Director Mohamed Mohamud listen to speakers during the East African Mental Health Conference on October 1, 2015

There is limited research evaluating the mental health needs and resources available to Somali adults living in Minnesota. As part of the Somali Mental Health Project, SAPA attempted to capture the Somali cultural view of mental health to gain a better understanding of the perceptions and attitudes around mental illness. The goals of the Somali Mental Health Project were to:

1. Convene an advisory board of professionals serving the Somalis in Minnesota;
2. Identify the effects of mental health stigma and attitudes within the Somali community;
3. Identify gaps in mental health services access and delivery to adult Somalis; and
4. Obtain recommendations and best practices in mental health service delivery to the Somali community and broader African communities in Minnesota.

Community Engagement:

Throughout 2015, SAPA implemented community-based conversations about adult mental health in the East African community. SAPA held 25 community conversations with an average of 10 participants each. Drawing on a diverse set of Somali and service provider perspectives, the content of the conversations included:

- Identifying community needs, gaps and solutions related to mental health in the Somali community;

- Identifying social and economic factors that create health and need to be addressed to eliminate health disparities; and
- Identifying and mobilizing key stakeholders for future work in the Somali community supporting healthy children and families and eliminating health disparities related to education, housing, income, and sense of security and community.

Overall, 220 participants took part in SAPA's community conversations as part of the Somali Mental Health Project. Participants included Somali adults (18 years and older) from Minneapolis, St. Paul and Rochester. Participants were representative of the Somali community, bringing to the discussion different levels of knowledge and experience regarding health care and mental health. Some participants were young adults between ages 18-25, who had lived in the U.S. most of their lives, and some were older adults who arrived in the U.S. as recently as six months ago. Although there was a diverse range of participants, the same themes emerged.

Community Conversation Findings:

Somali American Parent Association Community Engagement Specialist Asma Bulale speaks at the East African Mental Health Conference on October 1, 2015

One consistent theme among participants was the presence within the Somali community of intense stigma and negative associations regarding both admitting to experiencing mental health problems and seeking services for those problems. Words they associated with the term "mental health" included crazy and unstable. More culturally traditional explanations for mental disturbances included demons or jinn, evil eye, or "curses or negative thoughts about you from relatives" ("inkaar" or "habaar"). While there were focus group participants who did have more language to discuss mental health concepts such as trauma, anxiety and depression, they still agreed that this knowledge does not necessarily translate into people accessing available resources for mental health services.

Several participants also disclosed a general discomfort with Western doctors and other service providers and a preference for seeking religious counsel and guidance. Many participants shared that when people in the Somali community are experiencing mental health problems such as depression, anxiety, or more severe mental illnesses, they typically go to the Mosque, read the Quran, or seek support from other spiritual leaders. Participants agreed that part of the problem is a lack of awareness of available resources, as well as mistrust in doctors due to mutual misunderstanding. For example, Somali clients who have worked with doctors have been confused by medical language they do not understand and which is not translated well. They also reported having been prescribed medications for which the purpose and dosage details were unclear.

Another clearly identified reason Somalis don't seek mental health services even when issues are clearly identified is stigma in the community due primarily to lack of understanding and awareness of mental health concepts, as well as historical notions of a strict dichotomy between "fit" and "mad." Participants shared that people "don't want to be labeled by the community as being 'crazy'", and that the main reason people do not seek services is "stigma – that the community might think they are 'crazy.'" Somalis typically live in close community with one another and families are often involved in services typically designed for individuals in the Western mainstream health care model. This leads to concerns about damaging not only the Somali community member's own reputation, but that of his or her family

as well. Additionally, traditional Somali culture does not understand a spectrum of health/wellness that allows for temporary periods of illness that are treatable and can be overcome, making the label of "crazy" permanent and particularly damaging.

When asked what should be done to ensure that more Somalis get the care they need and that providers are more prepared to work with their clients, participants offered the following ideas:

- More community education and materials with relevant and appropriate language;
- Better training for interpreters working in mental health services so they know correct terminology;
- More outreach to raise awareness of mental health issues and services in the community; and
- More research on mental health issues specific to the Somali community.

Participants also agreed that many service providers do need to change their approach. Some of the ideas shared were more opportunities for service providers to receive training around "cultural sensitivity" so that they better understand the stigma associated with mental illnesses in the Somali community, better knowledge of effective language and vocabulary to use with Somali clients, and an emphasis on the importance of effective and well-trained interpreters. These efforts, participants felt, would "break the stigma" and encourage more Somalis to seek the services they need.

East African Mental Health Conference:

On October 1, 2015, SAPA convened the East African Mental Health Conference, which was attended by 176 experienced service providers, educators and policy makers. Conference sessions included:

- Improving the Mental Health of Somali Women: Thinking About Maternal Mental Health;
- Mental Health of Somali Refugees and Stigma;
- Somali Mental Health: Concepts and Best Practices;
- Maternal Health & Wellness in East African Women; "But I'm not crazy" (how to treat Somalis who deny or minimize mental health issues).

Attendees offered many practice techniques they have developed in their work with Somali clients and the larger East African community. The following is a list of several of those ideas and techniques:

- Better care coordination among case managers, social workers, therapists, ARMHS practitioners, psychiatrists, etc.
- Use specific language and vocabulary with Somali clients that focuses on symptoms and somatic experiences rather than diagnoses and "labels."
- Focus on the concrete and visible behaviors rather than abstract thoughts.
- Consider community and family networks of Somali clients rather than maintaining a strictly individual focus.
- Incorporate religious healing practices into clinical services and treatment plans.
- Provide more education for service providers on Somali worldviews so the providers are better able to help Somali clients that align with their cultural traditions and worldviews.
- Provide more education for Somali community members about basic mental health concepts and services in an effort to destigmatize mental illness.

In feedback, 85 percent of conference attendees reported that one of the most beneficial aspects of the conference was the opportunity to listen and learn from what East African community members shared. Overall, attendees also noted that discussions felt inclusive, allowing both Somali and non-Somali participants to engage in productive dialogue. Breakout sessions allowed for specific topics to be

discussed in depth with opportunities for presenters and participants to share insights and identify opportunities for further discussions.

Many attendees reported leaving with a greater understanding of Somali culture and the importance of developing a process-oriented approach to continuing to develop their own competency in practice in accordance with high expectations from community members.

Finally, attendees noted that by detailing Somali mental health perspectives, the conference presenters encouraged the development of innovative ways to reduce stigma in East African communities.

Recommendations:

Throughout the Somali Mental Health Project, five main actionable issues came to the forefront of community-based conversations and East African Mental Health Conference sessions:

1. Better handling of language and communication differences, including referrals to specialists and how interpreters are engaged in service provision models.
2. More creative use of interpreters or the idea of creating a new position for cultural brokers as community mental health workers.
3. More consistent and thorough practices of communicating about medication and treatments.
4. Engaging more service providers who specialize in providing services for Somali and East African community members whenever possible.
5. Service providers must be engaged in communities they are serving. Service providers can further bridge the gap and ensure clients are receiving the best services in ways that are relevant and acceptable by increasing their knowledge of East African communities and supporting service models that encourage community involvement and engagement.

Additional Information:

MDH Website: Minnesota Refugee Health Provider Guide – Mental Health
(https://www.health.state.mn.us/communities/rih/guide/10mentalhealth.html)

MPR News: Mental health workers hope to overcome stigma in Somali community (10/1/15)

KARE 11 News: Somali community takes on mental health (10/1/15)