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Community Needs Assessment of Somali Refugees' Mental Health Needs

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Abstract

Within the Somali immigrant and refugee community there are severe stigma and negative associations regarding both experiencing mental health problems and pursuing services for those problems. According to research, both process and content adaptation must be made in providing mental health supports to Somali immigrants and refugees. Understanding the experiences and prominent needs of Somali refugees will assist social workers in offering mental health services that are culturally responsive and help social workers promote social justice through examining and addressing health disparity issues. This independent study project reviews the literature on the mental health needs of immigrants and refugees and explores insights on practice models and successful interventions. Further, this independent study proposes and outlines methods for a needs assessment.

Keywords: Needs Assessment, Mental Health, Refugees, Somali, Cultural Competence, North Dakota, Fargo-Moorhead

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Introduction
Community Needs Assessment of Somali Refugees' Mental Health Needs

There were twenty-six million refugees worldwide at the end of 2019 (United Nations High Commissioner for Refugees, 2020). Due to more than two decades of conflict, a massive population displacement occurred in Somalia (Betancourt, et al., 2015). The United States began the first resettlement of refugees from Somalia in 1990. According to the Centers for Disease Control and Prevention [CDC] (2017), more than 47,000 Somali refugees arrived in the United States between the years 2010 and 2016. Many Somali immigrants and refugees relocate to states with well-established Somali communities following their initial resettlement in the United States. Minnesota receives a considerable number of these secondary refugee arrivals and as a result, Minnesota is home to the largest Somali immigrant and refugee community in the United States (CDC, 2017).

Somali refugees in Minnesota face a variety of complicated challenges and their needs are vast. Schuchman and MacDonald (2004) note that in addition to experiencing cultural and language disparities, Somali refugees encounter racism, frequently have limited literacy abilities, find minimum wage employment and have trouble supporting their families. Somali refugees have difficulty with acculturation due to the impact of war trauma, social isolation, and change in social status (Schuchman & MacDonald, 2004). The mental health of populations who have been displaced by force is the focus of considerable clinical work and research. This area of study seeks to comprehend the relationship between biological, social, psychological, and cultural processes and establish a spectrum for identifying levels of integration, from successful integration and adaptation to persistent mental illness (Fazel & Betancourt, 2018).

Culturally, Somalis do not conceptualize an integrated health model that considers collectively the role of physical health and disease, mental health, and mental illness

(Schuchman & MacDonald, 2004). Amid the Somali refugee community there is a harsh stigma and an undesirable association with enduring mental health struggles and seeking services for those struggles. To effectively address the mental health needs of Somali refugees, social workers must learn and use a culturally sensitive framework for understanding human development (Fondacaro & Harder, 2014). Ecological theory and conservation of resources theory are helpful for social workers to understand when attending to the mental health needs of Somali refugees. Clinical methods are not adequate in addressing the numerous resettlement matters refugees face day-to-day. Social workers can implement and advocate for culturally unique methods to focus on the specific mental health needs of Somali refugees**.** The health disparity and health equity issues facing Somali refugees must be examined and addressed to assist in meeting the mental health needs of refugees and to promote social justice. Being healthy, both physically and mentally, is necessary for refugees to overcome economic, environmental, and social disadvantage.

This Independent Study Project will apply theoretical and empirical findings to propose a mixed methods framework for conducting a community needs assessment for Somali refugees' mental health needs in a Minnesota community. The intended benefit for this Independent Study Project is to develop knowledge to help social workers address the mental health needs of Somali refugees. This research intends to promote culturally sensitive practice with the Somali refugee community, specifically, in the area of mental health interventions. Further, this research can guide efforts in securing grants and other supports to improve mental health services for Somali refugees.

Literature Review

Resettled refugees, like the Somali diaspora, differ in significant respects from other immigrants who come to the United States. First, refugees are referred to as "forced" immigrants as compared with immigrants who have prearranged their migration decision. Refugees do not voluntarily decide to migrate but are forced from their home countries due to circumstances beyond their control (Bernstein & DuBois, 2018). In many instances, when refugees flee from persecution and brutality, they make hastily formed departures leaving them with few material belongings and separated from family members and other social connections (McCabe, 2010). While waiting for permanent resettlement, refugees typically experience a lengthy time of displacement in refugee camps after their involuntary departure from their country of origin (Bernstein & DuBois, 2018). Due to these traumas, many refugees encounter physical and mental health difficulties that, without sufficient attention, can persist and have long-term consequences as they integrate in the United States (Ellis et al., 2016). While living in limbo within refugee camps, adults might not be allowed to work, children may lack school access, and medical care and social services may be limited. These experiences can produce major challenges following arrival in the United States (Bernstein & Dubois, 2018).

Theoretical Models

Applying Bronfenbrenner's (1977) ecological theory ensures that refugees, in this case, are assessed within the framework of their social environments. Ecological theory explores the interaction between the individual and their cultural environment through microsystem, mesosystem, exosystem, and macrosystem levels. In an ecological model, behavior is understood in terms of an individual's adaptation to resources and conditions in the environment (Suarez-Balcazar et al., 2014). Bronfenbrenner (1977) noted that to understand human

development a person must go beyond the noticeable observation of one on one behavior and investigate multi-level systems of interactions, not limited to a single setting. For example, ecological theory urges the consideration of various factors that may impact the mental health of Somali refugees as they adapt to a different country. The influence of the Muslim faith and cultural traditions shape an individual refugee's perspective on mental health. Ecologically speaking, a refugee' functioning cannot be assessed without exploring their environment at each level, such as family system, neighborhood, community and government, and society and culture (Frounfelker et al., 2017).

When facing disaster and traumatic events a person's resilience depends primarily on their preservation of resources, according to Hobfoll's conservation of resources theory (Ellis et al., 2013). Ellis et al. (2013) note this theory might hold significant relevance for refugees as they often experience substantial loss of resources when they flee to countries of resettlement. Hobfoll et al. (2011) examined the importance of considering resource loss as a framework to address mental health needs, especially among those who experience trauma within a disaster or other situations where substantial resource losses are commonplace. Mental health interventions with refugees might be more helpful when resource gaps are directly focused on as integral elements of treatment (Ellis et al., 2013). Generally, refugee children's experience of resettlement and resource loss is pervaded by the experience of their parents (Betancourt et al., 2015). Ellis et al. (2013) adapted trauma systems therapy to assist refugee children to gain control over emotions and behavior by decreasing the current pressures and threats in their school environment and improving their capacity to regulate feelings.

Culturally Competent Supports/Services

Supports and services offered to Somali refugees must be culturally responsive. Culture impacts the ways in which society looks at sickness and health. The way that refugees from

underdeveloped nations construct, understand, and face mental health is vastly different from how individuals from developed nations perceive mental health (Bettmann et al., 2015). Thus, for Somali refugees, customary clinical mental health services in the United States are typically underutilized as these clinics are culturally alien to Somali refugees who have their own distinct ways of understanding and reacting to mental health distress (Miller & Rasco, 2004). Clinic-based services are minimally useful in attending to the various displacement related stressors that refugees face daily. Examples of these stressors include residing in poverty, loss of social networks and a sense of isolation and lack of social supports, unemployment, loss of former valued social roles and pursuits, and not having the knowledge and skills needed to navigate their new community (Miller & Rasco, 2004). It is often difficult for refugees to seek suitable mental health services and share their past. In Somali culture, for example, there is no cultural context to manage the trauma of sexual violence caused by the custom of 'hisaut', which forbids the discussion of sexual matters (Haffejee & East, 2015). Somali adolescents look to each other and their siblings for both emotional and tangible supports. Social workers can build on this intra-generational safety net and offer support groups to refugee youth in community spaces to grant them a platform to share the pressures they face, especially in regards to parental expectations, and identify ways to communicate with their parents to foster positive family functioning and favorable mental health for refugee youth (Frounfelker et al., 2017).

Social workers can modify and tailor mental health interventions that have been utilized with other populations to meet the needs and context of refugees (Isakson et al., 2015). When assessing mental health needs of Somali refugees, their family, community, and larger cultural background should be considered. Involving family members in the assessment can assist in enabling the development of a trusting relationship with the social worker (Kronick, 2017).

Content adaptions such as learning key phrases in Somali related to greetings, using subjective units of distress as a measurement of distress throughout interventions, and making home visits to help with initial apprehension of attending a clinic setting, all can assist Somali refugees in appreciating the effort social workers are displaying to support them (Fondacaro & Harder, 2014).

Because parental involvement in schools is regarded as critical to student success in the United States, refugees can be disadvantaged when they are unfamiliar with the practices and when their own cultural beliefs conflict with expectations in their new communities, or when they are consumed by other pressing needs (McBrien, 2011). Research has revealed unique needs and differences with respect to refugee children's schooling in the United States. Overall, the differences indicate the need for educators and other service providers to be aware of the international backgrounds that bring refugees to their newly resettled communities and how the cultural differences can create a multitude of challenges for refugee populations. (McBrien, 2011).

Cultural brokers are necessary and encouraged when implementing mental health programming with Somali refugees. Kronick (2017) noted that culture brokers, whose function it is to facilitate the interpretation and negotiation of non-linguistic and cultural context, are valuable in mental health assessments involving Somali refugees. A cultural broker is a person who is well-informed in two cultures and is able to deliver both interpretation and a delicate understanding of both cultural viewpoints (Ellis et al., 2015). Along with the importance of utilizing cultural resources and extended family networks, including cultural brokers on mental health teams is also imperative (Tyrer & Fazel, 2014).

Health Disparity and Health Equity

Examining and addressing the health disparity and health equity concerns facing Somali refugees can assist in meeting their mental health needs and promote social justice. Health disparity refers to poorer health outcomes experienced by members of underprivileged demographic groups as opposed to the better outcomes afforded to groups with more social and economic capital. Health equity assumes an obligation to decrease, and eventually remove disparities in health (Braveman, 2014). Quality medical care is not the only resource needed to be healthy. Community based education and health-promoting social and physical conditions in households, workplaces and neighborhoods are also necessary. Health disparities and health equity are interwoven. Health equity denotes social justice in health. Health disparities are the metric used to gauge growth toward attaining health equity (Braveman, 2014).

The universal right to health is a basic human right. It is essential that the health needs of refugees be sufficiently addressed. As noted in the National Association of Social Workers (NASW) Code of Ethics (2018), one of social work's core values is that of social justice. In following the ethical principle of challenging social injustice, social workers engage in social change especially for vulnerable and oppressed populations. Social workers endeavor to make sure that refugees have access to essential information and resources, equality of opportunity and consequential participation in decision making (NASW, 2018). Developing and implementing mental health policies and programs that are ecologically based and resource preserving can assist Somali refugees in finding and maintaining wellness.

Research indicates both process and content adaptations are necessary to address health disparity issues when providing mental health related services to Somali refugees. Social workers need to move out of the traditional settings of out-patient clinics and schools into the neighborhoods where refugees reside, enlarge the range of roles they play, and create

partnerships with Somali leaders to make an impact on lowering distress and promoting wellness with refugees (Miller & Rasco, 2004). The use of focus groups, informal conversations with elders, and trained interpreters are key actions in generating relationships, security, and subsequent trust of social workers associated with school districts and mental health clinics (Fondacaro & Harder, 2014). A standardized mental health screening for Somali refugees should be a component of the comprehensive health assessment offered nationwide to refugees at public health agencies (Polcher & Calloway, 2016).

In addressing refugee health disparities, Pejic et al. (2016) research data showed positive results from implementing a community-based, family focused support intervention concentrated on acculturation struggles experienced by Somali refugees. The study involved a group facilitator who was trained in behavioral health and with connections to the Somali refugee community providing a culturally pertinent psycho-educational based parenting support program to Somali mothers at a community refugee center**.** An interpreter, who was bilingual and bicultural, had shared responsibility and engagement with the facilitator to create security and trust in the group. Using a refugee peer group format to deliver community support services that build upon collective cultural experiences may assist in decreasing the stigma that is associated with receiving mental health supports for many Somali refugees (Pejic et al., 2016).

Pratt et al. (2017) implemented a community-based program that effectively addressed refugee behavioral health disparities and aided in developing a support network for Somali refugees. Bilingual Somali female community health workers were trained to deliver a cognitive behavioral therapy model called Living Life to the Full to Somali refugee women. Through outreach, each community health worker recruited five Somali-born women who wanted to participate in the eight-session program. The participants rated their degree of happiness and

level of anxiety at the beginning and end of each session through self-rating visual scales for mood. Focus groups at the end of the program were asked about positive or negative effects they experienced while involved in the program. Focus group data indicated the Living Life to the Full intervention was positively accepted, particularly due to the delivery of the curriculum by a Somali community member. Gains in problem solving skills, stress reduction, and anger management were reported by participants. Participants also believed the intervention aided in addressing some of the stigma related to mental health in the Somali community (Pratt et al., 2017). Based on qualitative and quantitative data analysis, a CBT intervention delivered by bilingual community health workers was successful and had positive impact in both engaging Somali refugee women and increasing their self-rated mental health (Pratt et al., 2017).

Halcon et al. (2010) successfully addressed the health disparities of East African refugee women through a strengths-based, community delivered, psychoeducational mental health intervention that focused on resilience instead of trauma related causes and symptoms. The intervention, called health realization, presented information to female refugees using basic, understandable terms through highly interactive teaching methods that included storytelling, role-playing and group discussions to help address the women's daily stresses. Somali community coordinators co-facilitated the sessions and interpreted for both the instructors and participants. Teaching materials were written in the Somali language (Halcon et al., 2010). For each session, transportation, childcare and food were provided to the participants. Through post-intervention feedback, participants rated child-care support and transportation as essential to their accessibility to the intervention (Halcon et al., 2010).

Betancourt et al. (2020) implemented research using an intervention that improved health equity for Somali refugees. The program included home visitors, who were refugees from the

Somali community, had an association with community advocacy and were instructed and supervised by licensed clinical social workers, providing weekly preventative interventions by carrying out the Family Strengthening Intervention for Refugees (FSI-R) modules to Somali Bantu refugee families. Through a community-based participatory approach, the research found the FSI-R intervention was acceptable and feasible and has potential for improving refugee families' mental health and family functioning (Betancourt et al., 2020).

Refugee Children

Specific interventions addressing health disparity and health equity of refugee children were found in the literature. Fazel and Betancourt (2018) noted that many refugee children display substantial resilience and strength while navigating a considerable number of adjustments and challenges; but an amount of them, due to earlier experience and existing family, school, and living situations, can develop major mental health problems with related implications for academic and social performance. For example, mental health struggles may obstruct a refugee child's ability to adapt in the classroom and learn a new language. More common in refugee children than in the general population are the issues of depression, anxiety, and sleep disturbance (Fazel & Betancourt, 2018).

Overall, youth in the United States, especially youth from minority racial and ethnic upbringings have restricted access to mental health supports. For refugee youth these dynamics are even more urgent as they face many language and cultural obstacles to seeking and obtaining mental health supports (Ellis et al., 2013). Consequently, despite a very elevated level of need, very few refugee youths receive mental health supports (Ellis et al., 2010). It is essential that sustainable and accessible interventions are developed for refugee youth.

Mental health interventions are needed in settings more easily accessed by refugee children and families. The findings of Tyrer and Fazel's (2014) systematic review of school or community-

based mental health interventions for refugee children imply that interventions carried out within the school setting can be effective in assisting children overcome struggles associated with forced resettlement. Training non-mental health professionals, such as school paraprofessionals and liaisons, to deliver mental health interventions could help tackle this need (Tyrer & Fazel, 2014).

Research by Ellis et al. (2013), in response to the recognized needs of Somali refugee youths in New England, created a multi-tiered prevention and intervention program called Project SHIFA (Supporting the Health of Immigrant Families and Adolescents). Shifa in Somali means health. Project SHIFA was planned around a public health approach promoting prevention through coordinated community level systems. Refugee students in Tier 1 were part of community wide engagement activities and parent outreach. Tier 2 provided school-based preventative skill building groups to all Somali English language learner students. Refugee students referred to Tier 3 received direct mental health interventions through Trauma Systems Therapy (TST) at school and Tier 4 students received TST interventions at both school and home, along with case management and advocacy services (Ellis et al., 2013). The study found that Project SHIFA is a favorable approach for connecting with and treating refugee teens in the school setting. Project SHIFA used a multi-tiered approach to create a foundation of trust by providing community building and non-stigmatized skill development groups within school surroundings (Ellis et al., 2013). Because TST specifically focuses on social environmental stressors, including stressors that are associated with everyday resource hardships, it might be a particularly appropriate model for working with refugee teens and youth (Ellis et al., 2013).

The degree to which a child and their family feel accepted and partake in their local communities may affect the mental health of refugee children, thus it is essential to support families in the varied components of the acculturation process (Fazel & Betancourt, 2018). Fazel

and Betancourt (2018) found better parental engagement in school and educational experiences can help refugee children's mental health. Parent engagement interventions have resulted in decreased levels of depressive and PTSD symptoms and enhanced academic performance. Social workers who deliver mental health services for people from refugee backgrounds must be assured that the therapeutic interventions they provide are appropriate and effective for the clients they serve (Murray et al., 2010).

Firsthand Experiences

It is imperative social workers learn from, collaborate, create, and implement interventions with Somali refugee partners at local community-based organizations to successfully support Somali refugee mental health and wellness and promote social justice. Five Somali born community-based providers shared information regarding how they perceive mental health is viewed by the Somali refugee community and they provided ideas that local service agencies should consider when striving to assist refugees in overcoming social, economic, and environmental difficulties.

Jayhan Abdalla is a case manager and employment specialist at the Somali Community Development of North Dakota, Inc. (SCDND). J. Abdalla received her social work degree in Kenya and came to the United States as a refugee in 2015 (J. Abdalla, personal communication, October 21, 2020). SCDND promotes successful integration of refugees in the community through meaningful programming and services such as mentoring, conflict resolution, tutoring, employment placement, and advocacy (Somali Community Development, n.d.). The mission of SCDND is to create, build, and strengthen refugees socially, economically and educationally to be a self-sufficient and independent community. SCDND is funded by grants, with the local United Way being a top funder. J. Abdalla noted she receives referrals from local police and schools to provide case management services to Somali refugee families due to family conflicts

and children not coming to or failing at school (J. Abdalla, personal communication, October 21, 2020).

J. Abdalla shared the Somali culture does not understand the spectrum of mental health and for the most part, talking about mental health is taboo. When discussing or trying to teach Somali refugees about mental health, J. Abdalla suggested focusing on both symptoms, such as not wanting to go to school, diminished interest in preferred activities, crying often, irritability, and teaching coping mechanisms/strategies to address the symptoms (J. Abdalla, personal communication, October 21, 2020). J. Abdalla has found it helpful to connect mental health topics to practical matters when working with the Somali refugee community. J. Abdalla described two examples of practical wellness activities she helped implement. The first was a support group for female Somali high school teens who were planning to go to college. While the teens participated in creating henna designs, J. Abdalla lead a discussion and wrote up on a poster board, emotions the teens experience. J. Abdalla then provided education on healthy activities the teens could do when experiencing certain emotions. The second activity was a cooking class for Somali refugee mothers. J. Abdalla collaborated with a nutritionist from the Cass County / North Dakota State University's extension program to co-teach about nutrition and how nutrition and diet affects an individual's moods and emotions. It is critical that the provider of Somali refugee social supports be the same gender as their audience (J. Abdalla, personal communication, October 21, 2020).

J. Abdalla suggested social workers and other mental health providers form an alliance with the leader of prayer at the community mosque. Recently, the local leader of prayer spoke with the Muslim community regarding the issue of fraud related to county food and cash assistance. He spoke of how fraud is a sin and immoral within the Muslim faith. The leader of

prayer could be a key person to introduce various mental health and community health providers to Somali community members to aid in the acceptance of their services (J. Abdalla, personal communication, October 21, 2020).

According to J. Abdalla, there is an identity crisis among Somali refugees. Somalia has not been a stable country for half a century. Somali refugee elders were born in war and have moved around to other countries for safety. Locally, Somali beliefs and traditions are being challenged by the difference of opinions between Somali refugee youth and their parents (J. Abdalla, personal communication, October 21, 2020). J. Abdalla has observed Somali refugee parents waiting until their children are almost 18 years old, legal adults, to seek help with their challenging behaviors, such as disobeying family rules, drinking alcohol, using drugs, not going to school, when actually the challenging behaviors started several years before. There have been family conflicts due to the difference of opinions between Somali youth and their parents regarding cultural beliefs (J. Abdalla, personal communication, October 21, 2020). J. Abdalla believes the younger generation in the Somali community are more open to asking for help with mental health issues. Because Somali mothers are most often in charge of the care of their children, J. Abdalla proposed forming mother/daughter support groups to assist in educating and modeling effective communication skills and participating in positive events (J. Abdalla, personal communication, October 21, 2020).

Shire Mohamed, Director of Youth Engagement at the Somali Community Development of North Dakota, Inc., came to the United States in 2011 as a refugee from Somalia. S. Mohamed believes most Somali refugees are in denial of their historical trauma and its effects on their physical and mental wellbeing, whereas Iraqi refugees, for example, will typically acknowledge they have been traumatized by their refugee experience (S. Mohamed, personal

communication, October 14, 2020). According to S. Mohamed, there is no good translation in Somali for trauma. Somali people believe in spirits and that prayer is required as much as medication to heal physical illnesses (S. Mohamed, personal communication, October 14, 2020). Somali refugees may tell you about the symptoms of mental health difficulties, but they will most likely not accept the symptoms as a mental health issue. In Somali culture, S. Mohamed stated the term mental health is associated with a crazy person and in Somalia a crazy person is someone who runs wild in the streets. S. Mohamed described the practice of family members tying up a loved one in Somalia if they displayed severe mental illness, especially in the more rural areas of Somalia. In larger cities like Mogadishu and Hargeisa, there are residential hospitals for people suffering from severe mental illness (S. Mohamed, personal communication, October 14, 2020).

If mental health difficulties appear to be an issue for a Somali refugee, S. Mohamed suggested first helping the Somali refugee's family out in tangible ways with other needed services that are more acceptable to pursue, such as assistance in completing employment or housing applications, to gain trust with families (S. Mohamed, personal communication, October 14, 2020). In Fargo, North Dakota schools, S. Mohamed explained culturally specific liaisons accompany new refugee students to classes their first day or two to help students transition into the school environment and better understand student expectations. S. Mohamed encouraged social workers and other mental health providers to pull in the concept of mindfulness as much as possible when assisting Somali refugees by teaching, modeling, and practicing exercises to physically calm their bodies and thoughts (S. Mohamed, personal communication, October 14, 2020).

S. Mohamed also provides Adult Rehabilitative Mental Health Services (ARMHS) to Somali refugees through his employment at Metro Behavioral Health in Moorhead. Metro Behavioral Health provides needed behavioral health services that are tailored to client capacity, present life context, and cultural background (Metro Behavioral Health, n.d.). Metro Behavioral Health serves culturally diverse clients, including refugees, in both Moorhead and Minneapolis, MN. The psychotherapists themselves are culturally diverse and bilingual. The psychiatrist on staff has over forty years of experience working with primarily minority and refugee patient populations (Metro Behavioral Health, n.d.). Through ARMHS, S. Mohamed provides services that instruct, assist, and support refugees in basic living and social skills to help restore the refugee's skills for managing their mental illness and everyday independence (S. Mohamed, personal communication, October 14, 2020).

Ahmed Issa, Somali liaison with Moorhead Area School District arrived in the United States as a refugee in 2008. Based on his own heritage and personal refugee experience, in addition to his work with supporting other Somali refugee families, Issa believes that in the Somali community, mental health concerns are more of a private matter which is dealt with within the immediate family (A. Issa, personal communication, October 22, 2020). A. Issa knows many Somali refugees in the Fargo/Moorhead community who he believes have Post Traumatic Stress type symptoms from their life experiences and refugee journey. According to A. Issa, families will go to medical appointments together. Somali refugee parents will most likely not accept a diagnosis they are not familiar with and will not take medicine they do not know about (A. Issa, personal communication, October 22, 2020). When trying to share academic and behavioral concerns, school staff should avoid labeling children. For example, A. Issa recommends teachers share specific characteristics and examples of the concern and what

the school is doing directly to address the concern. A. Issa believes sharing strengths and affirmative observations about the child over time will help to establish a positive and helping relationship with the parents. Somali refugee parents will most likely be more open to accept recommendations for needed academic and behavioral interventions if they believe the teacher appreciates their child's functioning (A. Issa, personal communication, October 22, 2020).

Cani Aiden is a Somali refugee and a community liaison officer at the Afro American Development Association (AADA) in Moorhead, Minnesota. AADA was founded in 2014 by a small group of culturally diverse New American college students in the Red River Valley. The students worked to pool their knowledge and experiences as immigrants and refugees to improve the lives of their families and cultural communities (Afro American Development Association, n.d.). AADA's founders observed how traditional ways of helping refugee families resettle were lacking in numerous ways, so they determined these existing mainstream community agencies needed new partners at the center of the refugee experience. By going to where refugees are, building on their capabilities, and forming connections, AADA has been able to help alleviate poverty and build capacities of New Americans and other diverse populations (Afro American Development Association, n.d.).

C. Aiden collaborates with the Moorhead school district, public health, community action partnership, law enforcement, and local government to support Somali refugees in the Fargo-Moorhead community (C. Aiden, personal communication, October 30, 2020). According to C. Aiden, mental health is a very sensitive subject in the Somali community. To help achieve success in supporting Somali refugee mental health and wellness, leaders and liaisons from the Somali community must assist in the process. C. Aiden stated developing a resource assisting relationship is also key. For example, a social worker should help with an

employment or housing matter and then offer wellness supports (C. Aiden, personal communication, October 30, 2020). Most recently, C. Aiden helped form a local CO-VID19 response team for the New American community in Fargo-Moorhead. Eight culturally diverse community liaisons have been trained by the Minnesota Department of Health to educate and assist local refugees about CO-VID19 facts, protocols, where to go for testing, and how to contact employers (C. Aiden, personal communication, October 30, 2020).

Simi Kasakwe, a first generation American from Liberia, founded the agency Motherland Health in Fargo, North Dakota in August 2018. According to S. Kasakwe, the mission of Motherland Health is to foster wellness for Americans and New American communities through culturally appropriate services. Motherland Health serves any community member requesting their services (S. Kasakwe, personal communication, October 27, 2020). S. Kasakwe stated the major barriers to refugees receiving mental health supports are lack of health insurance, transportation, and childcare. All Motherland Health services are free to clients. Motherland Health provides transportation to and from their agency and childcare onsite (S. Kasakwe, personal communication, October 27, 2020). Motherland Health assists community members who are fighting barriers to wellness. Because services are all funded through grants, and health insurances are not billed, there is no need to document mental health diagnoses. Therapeutic approaches are offered through culturally acceptable methods. Motherland Health receives a bulk of their referrals from other counseling agencies who can not provide needed services due to ecological barriers (S. Kasakwe, personal communication, October 27, 2020). S. Kasakwe believes a vital component in facilitating a successful mental health intervention to Somali families is providing childcare onsite. Offering quality interpreting services is also crucial when implementing supports for refugees (S. Kasakwe, personal communication, October 27, 2020).

The previous firsthand experiences from Somali refugee community-based partners pay critical attention to the mental health needs and supports of Somali refugees. The following methods for a proposed needs assessment seek to further address these elements for the Somali refugee community of Moorhead, Minnesota.

Methods

Understanding the experiences and prominent needs of Somali refugees will assist social workers in offering mental health services that are culturally responsive and help social workers promote social justice through examining and addressing health disparity issues. Needs assessments seek to identify deficiencies in certain populations. For this proposed needs assessment, a mixed methods framework will be used to explore the experiences of resettled Somali refugees in the Moorhead community and play a key role in understanding their mental health related issues. The complexity of Somali refugee mental health needs and challenges makes mixed methods research an essential tool for social workers to use. Mixed-methods research tells more of a complete story of the phenomena being researched. Mixed-methods research combines qualitative and quantitative research methods. Hill et al. (1997) note qualitative research offers a vivid and thorough description of the phenomenon being studied from individuals own frame of references. Instead of being limited by determined constructs, qualitative methods help researchers explore phenomena as they naturally happen, therefore allowing researchers to systematize and describe phenomena with more depth and richness (Hill et al., 1997). Quantitative research seeks to be generalizable to sizable populations by utilizing specific sampling methods and larger information collections. Providing important descriptive statistics about a population through quantitative data allows researchers to understand key characteristics of the phenomenon of study (Scarnato, 2019). Overall, combining qualitative and quantitative methods adds three valuable elements to this needs assessment: voices of Somali

refugees, wide range of analysis of the mental health needs of Somali refugees, and improved validity of the findings (Chaumba, 2013).

Participant Recruitment

Participants will be recruited from a community-based refugee organization in Moorhead, Minnesota through purposive sampling for all portions of the needs assessment. Purposive sampling will be used as it involves selecting participants the researcher finds most useful to the purposes of the research being implemented and assists in creating a full exploration and understanding of the research subject (Palinkas et al., 2015). Twenty participants, with refugee status, will be recruited for four focus groups of five participants each. The first and second focus groups will contain male youths between ages 12 to 18 and female youths between the ages of 12 to 18. The third and fourth focus groups will include adult males and adult females respectively. Participants will need to have been assisted by the community-based refugee organization regarding daily living stressors and issues. Ten community service organization leaders, such as leaders in public health, education, law enforcement, mental health, medical, and vocational services will be recruited for interviews. Finally, one hundred male and female participants from the Moorhead, Minnesota Somali community, at a minimum age of twelve years old, will be recruited for a wellness survey.

Data Collection

Open-ended questions will be used to collect data from the focus group participants to help gain insight into their experiences with resettlement as related to mental health needs. These expected findings are important for professionals and community organization working to deliver successful services for Somali refugees. Some examples of focus group questions to be used are: What was it like to live in your home country? How has life improved since getting to Moorhead? What was the most challenging time before you came to the United States and the

most challenging time since you have lived here? The estimated length for each focus group is approximately two hours and will be conducted at the local community-based refugee agency. Refreshments will be offered to participants during the focus groups. Each focus group participant will be given a $10 gift card to Target. The focus groups will be audio recorded and transcribed for analysis.

Semi-structured interviews with open-ended questions will be used to gather data from local community service organization leaders. Questions asked will help in understanding community providers' perspectives on services and processes needed to provide mental health supports to the local Somali refugee community. A few example interview questions include: What do you see as unmet needs of local Somali refugees? What culturally competent services do you provide Somali refugees? What are the barriers in your agency for meeting Somali refugee needs? What resources would help your agency meet Somali refugee needs? Interviews will be audio recorded and transcribed for analysis.

Quantitatively, a survey will be used to also collect data from participants. The survey will ask wellness related questions developed by the Minnesota Department of Health to help refugees determine if they may want to ask for support from a mental health professional. There are five categories with a total of forty yes or no questions. Participants will answer questions related to experiencing challenges in specific daily life activities. The categories for questions consist of: Sleep Problems, Appetite Problems, Problems with Your Nerves, Problems with Your Mood, Problems with the Way You Are Thinking or Behaving. The responses to these questions can help determine the mental health challenges these refugees are experiencing. The survey will be administered through SurveyMonkey. A weblink will be generated and made available to potential participants. Somali liaisons from a local community-based refugee

organization will assist participants as needed in completing the survey. Participants who complete the survey will be eligible for a drawing of five $10 gift cards to Target.

Data Analysis Approaches

The focus group and interview data will be analyzed using a thematic analysis framework. Thematic analysis frameworks allow an in-depth exploration of the data collected through qualitative methods. Through thematic analysis, themes within a data set can be identified, analyzed, organized, described, and reported (Nowell et al., 2017). Nowell et al. (2017) contend thematic analysis is a valuable method for exploring the perspectives of various research participants, drawing attention to similarities and differences, and producing unforeseen insights. Because thematic analysis is not theoretically based, it provides a very flexible approach that can be adapted for the needs of numerous studies, providing complex and full account of data (Nowell et al., 2017). The specific steps of the analytic process include coding the data, subsequently examining the data for redundancies in codes, and then inserting the data into categories. Emerging themes will be identified and recorded through an interactive and cyclical process to ensure adequate involvement with and awareness of the data.

The survey portion of the needs assessment will be analyzed using multivariate analyses. Multivariate analysis helps determine the relationship among several variables in a quantifiable way. Through multivariate analysis the interrelationships between variables such as age, gender, employment status, marital status, number of years in the US, and experiencing challenges in five or more specific daily life activities can be explored to determine what effects combinations of variables have on participants' mental health. One potential analysis is identifying predictive factors for depression among refugees. Associations between gender and depression or unemployment and depression are just two relationships that could be explored in the multivariate analysis process.

Conclusion

Anticipated Findings

It is anticipated the proposed needs assessment will project several factors as to why Somali refugees in the Moorhead, Minnesota could benefit from ecologically sound and resource enhancing community supports and services that may also positively address their mental health needs, as well as the barriers to receiving supports. The needs assessment findings will examine in more detail the pre and post migration adversities local Somali refugees experience and specific mental health challenges they face. Additionally, the needs assessment will help lay out recommendations to improve health disparities and provide culturally competent mental health services to Somali refugees. Finally, the anticipated findings of the proposed needs assessment can steer efforts in obtaining grants and other funding to advance mental health supports for Somali refugees.

Implications for Social Work Practice, Policy, and Education

This needs assessment can inform service implementation and inform both education and policy. Social workers must expand the scope of roles they perform and establish partnerships with Somali leaders to assist in lowering distress and promoting wellness among refugees (Miller & Rasco, 2004). Social workers must provide resource assistance in areas such as housing and employment to foster positive relationships and help alleviate the stresses that impact refugee mental health. Social workers must ethically care for their entire community. If needs are present and there are barriers, the needs and barriers must be addressed. In the matter of Somali refugee mental health needs, social workers must find and implement a more equitable distribution of health care services. Social workers must strive for the highest possible standard of health for all individuals, giving special interest to the needs of those at utmost risk of poor health based on societal conditions (Braveman, 2014).

Because the needs assessment findings will most likely recognize refugee parents' genuine interest in their children's education, in spite of their inability to participate according to their new communities' expected methods of involvement, helping professionals must remember refugee parents' current economic and cultural anxieties, as well as traumatic histories. It is crucial for school staff to be aware of cultural differences of refugee families and not to judge difference as incapability or inferiority (McBrien, 2011). Succeeding in school, both educationally and socially with peers, is a main factor in determining mental health functioning of refugee children (Tyrer & Fazel, 2014). Fostering social-peer relationships and encouraging a sense of belonging to the school community and the wider culture, are all ways schools can likely play an important role in preventing mental illness (Fazel & Betancourt, 2017). Interventions delivered in the safe and more informal setting of schools may offer non-stigmatizing services which refugee families may be more open to accept given the already established relationships with school personnel and the ease of access to children while at school (Tyrer & Fazel, 2014).

Social workers can assist in implementing innovative ways to address the mental health needs of Somali refugees. Creating and implementing mental health policies and community-based programs that are ecologically based and resource preserving are essential for Somali refugee wellness. The recruitment of and collaboration with Somali team members must be a priority for the creation of culturally sensitive approaches. Social work across countries is viewed differently and can impact mental health practices, thus local training of Somali mental health workers, Somali social workers, Somali cultural brokers, and Somali interpreters are critical to the success of mental health interventions offered to Somali refugees in Minnesota. Partnerships between refugee community-based programs, mental health providers, public health

and schools are critical in supporting the mental health of Somali refugees. Given the impact poor mental health has on individual well-being and the capacity for productive employment, it is imperative that social workers continue to study the mental health needs of Somali refugees and identify ways in which we can provide effective supports to promote social justice.

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