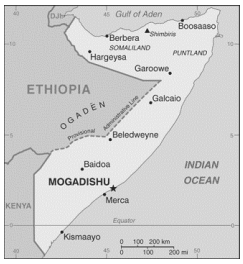


DHAAWAC AMA WAXYEELO MASKAXEED

"I live with this"

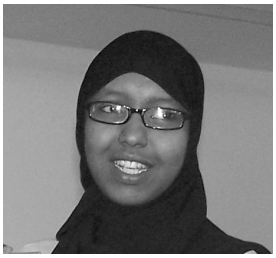
A report on

Post Traumatic Stress
In the Somali Community in Northampton
and their experiences of Health Services

Delivered by

Northamptonshire Somali Community Association
(NSCA)

May 2008

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Foreword:

Delivering Race Equality: An Action Plan for Mental Health Services was launched in January 2005. It gives a definition of Black and Minority Ethnic communities.

East Midlands CSIP has had a history of working with the Somali community in Northampton and I was delighted when they secured community engagement project resources.

The Somali community in Northampton is unique. I was not surprised to learn that this particular population are refugees of war and that there was a real but yet unmet issue of mental health challenges. The community have been proactive in the way they view mental health and how individuals and communities can take charge of their own recovery, support and treatment.

The outcomes of the report makes some key recommendations that the local commissioning team needs to recognise and develop into service delivery.

Since my involvement with the research group I have witnessed considerable growth of ideas and individuals from the project and I am delighted that some members of the research team have not only gained confidence but also paid employment.

Congratulations to all staff and volunteers at Northampton Somali Community Association on completing the project. The recommendations do not only have implications for commissioning and service delivery locally, but also nationally. I am pleased to announce that this project, design and outcomes have attracted interest internationally.

Well done and once again many congratulations

Asha Day
Regional Race Equality Lead
CSIP East Midlands

THE COMMUNITY RESEARCH TEAM

The following people were involved in the development and delivery of this project

1. **Abdirahman Abdi**

26 years old. Employed on this project as the co-coordinator and as the lead researcher in the Northampton Somali Community Group. Abdirahman had previously undertaken a similar project on the mental health needs of the Somali community in Northampton and has recently been appointed as a Community Development Worker (CDW). As the project coordinator he developed leadership and teamwork skills especially when under pressure met targets and deadlines.

During the course of the research Abdirahman developed good working relationships with the project supporters, community leaders, mental health staff, steering group members, charities and the community development worker in mental health with whom he worked closely.

2. **Barlin Haili**

24, an MA management student was employed on this project as a researcher and is currently employed by Milton Keynes PCT as a Community Development Worker. Prior to this project Barlin had not undertaken a social research study and thoroughly enjoyed her involvement in this project in particular working in a team to deliver a project that yielded multiple benefits to the community. The research enabled her to learn much about the community and herself. As a community activist Barlin dedicates her time, work, training and activities to the development of services attuned to the psychological, social and cultural issues of primarily economic immigrants. She successfully completed the University Certificate in Community Research.

3. Abdullahi Hussein

26 years old, married, father of two was employed on this project as a researcher. He was mainly involved in analysing the data and writing up the report and believes his involvement in the project enabled him to gain a better understanding of his own community. During the project Abdullahi learnt a great deal about health and social

care including which courses are available for those wanting to work in these fields; how to access these courses and career development opportunities. His attendance at the workshops enabled him to find more about what the other CE reaserch projects were doing and learn more about other community groups. Abdullah successfully completed the University Certificate in Community Research and is at present studying at University.

4. **Abade Ahmed**

40 years old. Employed in this project as researcher. Prior to getting involved in this project Abade had experience of working on many different projects within the Somali community including undertaking research focussing on substance misuse. He also served as Chairman Northamptonshire Somali Community Association NSCA for three years. Since his involvement with the research his knowledge about mental health and post traumatic stress has increased greatly and he is able to signpost community members to services. His experience from this project has enabled him to gain employment as a Community Health Trainer by Northampton PCT. Abade successfully completed the University Certificate in Community Research.

5 **Qadra Mohamed**

37 years old. Qadra was employed on this project as a part time volunteer community support worker. The experience and skills gained in this project were an added bonus as she was able to work with schools and parents and passed on much needed information about post traumatic stress and mental health in particular to vulnerable mothers who could not speak and write English. Qadra also attended a discussion forum in London and presented to a large audience, which increased her confidence. She successfully completed the University Certificate in Community Research.

STEERING GROUP MEMBERS

A Steering Group was set up by the project to oversee the research and consisted of a variety of stakeholders including representatives from the Somali community and from other community and voluntary sector organisations. However, the Steering Group meetings proved difficult to convene and often had a poor turnout but the

Community Development Team, Focus Implementation Lead, community leaders, Uclan Support Worker and CSIP engaged very well with the research.

Terms of reference were drafted and circulated to Steering Group members. These were discussed at the first Steering Group meeting where fifteen representatives were present. However, during the life of the project participation remained low and it proved difficult to recruit additional members as well as to adhere to the timetable of the research. The research methodology was drafted and distributed for comments to the Steering Group and community leaders but the lack of full involvement by Steering Group members in the design of the methodology was a further limitation to the research

ACKNOWLEDGEMENTS

The community researchers would like to express their sincere gratitude to:

- The 120 individuals who participated in the research, sharing their personal thoughts, experiences and spiritual journeys without which this project would not have been a success.
- Nasreen Akhtar - Support Worker UClan who has been an inspiration and always been available to offer her valuable advice as well as her continuous support and encouragement.
- Members of the Steering Group for their knowledge, guidance and individual expertise.
- UCLan, CSIP and East midland FIS site for choosing the Northamptonshire Somali community.
- Mohamed Arab and his team for their continuous support.
- Ann Crowder Northamptonshire Healthcare Trust/FIS Lead.
- Asha Day – Race Equality Lead East Midlands.
- Jim Lillis - Service Development Manager.

EXECUTIVE SUMMARY

Delivering Race Equality, An Action Plan for Mental Health Services was launched in January 2005. It gives a definition of Black and Minority Ethnic communities.

It builds upon 3 building blocks

- Community Engagement
- Better and More intelligently used Information
- Appropriate and Responsive Services

More recently many have also suggested that another section, workforce, needs also to be included in the above.

The policy also puts forward 12 service change characteristics. This project was designed to address the following service change characteristics.

- Less fear of mental health services among BME communities and service users;
- Increased satisfaction with services.
- A reduction in the rate of admission of people from BME communities to psychiatric inpatient units.
- A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and
- A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

Background and Setting the Scene

This study focuses on post traumatic stress disorder *(PTSD)* among the Somali community in Northamptonshire and was undertaken by Northamptonshire Somali Community Association (NSCA). The NSCA works with the Somali community in Northampton, particularly those living with mental distress through the concept and practical methodology of community engagement and community development with particular attention to the mental health pathways, including admission, treatment and discharge and importantly post discharge and community support.

As part of this research NSCA recruited and trained five community researchers and engaged with 100 people (with 92 responses received).

As an outcome of this research project the 5 researchers employed have gained:

- Certifictes in community research
- Practical experience in undertaking research
- Confidence
- 3 individuals have since gained paid employment

The Somali community has gained:

- A better understanding of the variety of services available
- De-mysitfing mental health services/organisations
- A CDW working with the Somali community
-

History of the Somali Community

For the last eighteen years people from Somalia have suffered greatly in the civil war in their homeland. Many of them who now live in Northampton have experienced trauma, physical atrocities and loss of a loved. Many Somalis lost property and wealth overnight and spent prolonged periods of harsh life in refugee camps in Africa before coming to UK.

It is widely recognised that underserved communities experience social and material disadvantage and face barriers in their access to services. Social exclusion is a symptom and product of institutional racism and stereotypes. Within a health context social exclusion and institutional racism have contributed towards significant differences in health outcomes for underserved communities including the Somali community.

Mental Health & Cultural Concepts

The mental health system and in particular for some, the notions of the self and distress are 'Eurocentric' and exclude to the detriment of the Hippocratic oath of 'doing no harm', alternative cultural, ethnic, gender and spiritual perspectives. Within the 'system' even western traditions of spirituality are ignored and preference is given to a biomedical model - which while acknowledging the causes of people's distress fails to adequately engage with peoples experiences. De-contextualisation of people from their experiences, culture, notions of their self, religion and spirituality leads to inequalities in mental health outcomes.

Summary of Findings
The study found that Somali community participants talked about the following distinct themes:

- ***Experience of traumatic events***

  55% said they had experienced a traumatic event in Somalia and UK.

- ***Reason for coming to UK***

  40 % said they were fleeing civil war - 24% fear of persecution.

- ***Family loss during the war in Somalia***

57% had lost family member(s) during the civil war - 57% said this had affected their mental and emotional wellbeing 66% didn't seek help or advice.

- ***Post traumatic stress awareness***

  52% didn't understand what post traumatic stress meant.

- ***Care* they received**

  75.8 % felt that being Somalian made negative differences to the care they received.

- ***Seeking help or advice***

  52.1% of participants said didn't seek any help or advice.

- ***Service awareness***

  45.6% said they were not aware of services available to help them in relation to post traumatic stress disorder PSTD and mental health.

- ***Service improvement***

  72.8% said services could be improved for the Somali community in Northamptonshire.

  The study found that the Somali community did have a clear idea of what helped them in times of difficulties and mental distress as a result of which the following key recommendations were made:

RECOMMENDATIONS:

For Mental Health Service Providers

1. Cultural competence of services
2. Advocacy and community education
3. Service development
4. Health promotion strategies

For Community

Somali community organisations, community leaders, faith leaders and community health workers should develop and implement an Advocacy Strategy with the goal of creating community awareness and empowerment in the area of mental health service.

Conclusion

This study and the themes that emerge are not new as they reaffirm much of what is known already. It is clear that people have and continue to experience social exclusion and live with stigma, racism and have clear personal and social identities that are informed by their faith and beliefs. They are also certain and articulate and suggest to service providers responses that would be congruent with their needs and which crucially offer 'choice' and thus increase the possibilities of recovery and non medical interventions.

The research clearly indicates that a large proportion of the Somali community have suffered from the trauma of war - physical and mental distress. Before the civil war most people were financially well off with properties and jobs. Educated people were practicing professions they had been trained in and overall the country harboured good hope for the future. All this disappeared overnight with the community relegated to the lower strata of society causing stress, depression, mental distress and loss of self-esteem amongst the population.

This study will only be of value if the proposed recommendations are taken forward and implemented and a timescale for reporting back the outcome to the community is set in motion.

The team of researchers and workers have expressed a commitment to the project and would expect to see the report being implemented within the policy and/or practises of the primary services, NHS and PCT's

Whilst the project did not intentionally look to addressing the 2 service change characteristics below, whilst undertaking this project opportunities developed to work in collaboration with the local mental health service provider, third sector organisations to also have some impact upon them.

More BME service users reaching self-reported states of recovery

- A more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective.

This was done through Wellness Recovery Action Planning training specifically designed and delivered to the Somali Community. The Somali Community itself has also taken on board principles of recovery and has gone on to provide peer support for their own community.

The Centre for Ethnicity and Health's Model of community engagement

Background to the community engagement model

We often hear the following words or phrases:

- Community consultation
- Community representation
- Community involvement/participation
- Community empowerment
- Community development
- Community engagement

Sometimes these terms are used inter-changeably; sometimes one term is used by different people to mean different things. The Centre for Ethnicity and Health has a very specific notion of community engagement. The Centre's model of community engagement evolved over several years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health (DH) awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire (UCLan) to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The DH had two key things in mind when it commissioned the work; first, the DH wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done.

If all the DH had wanted was a needs assessment and a 'glossy report', they could have commissioned researchers and produced yet another set of reports that may have had little long term impact. However this scheme was to be different. The DH was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; however they would have proven access to the communities they were working with, the potential to be supported and trained, and the infrastructure to conduct such a piece of work. They would be able to use the nine-month process to learn about drug related issues, and how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity and Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams (DATs). It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas of work. These include:

- Substance misuse
- Criminal justice system
- Policing
- Sexual health
- Mental health
- Regeneration
- Higher education
- Asylum seekers and refugees

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- Young people
- People with disabilities
- Service user groups
- Victims of domestic violence
- Gay, lesbian and bi-sexual and trans-gender people
- Women
- White deprived communities
- Rural communities

In addition to the DH, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, the National Institute for Mental Health in England, the Greater London Authority, New Scotland Yard, Aimhigher and the Welsh Assembly.

The key ingredients of the model

There are four essential ingredients or building blocks to the UCLan Community Engagement model.

1. An issue about which communities and other key stakeholders such as commissioners and policy makers share some concern

The issue can be almost anything, but frequently involves a concern about inequitable access to, experience of or outcome from services. The community and other stakeholders may not agree about the causes of inequity or what to do about it – the key however is that they share a concern. Usually the concern will be framed within some kind of local, regional or national policy context (e.g. teenage pregnancy reduction).

2. The Community

According to the Centre for Ethnicity and Health model, a community engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a host community organisation. This may be an existing

community group, but it might also be necessary to set up a group for this specific purpose of conducting the community engagement research.

The key thing is that this host community organisation should have good links to the defined target community[1], such that it is able to recruit a number of people from the target community to take part in the project and to do the work (see section on task below).

It is important that the host community organisation is able to co-ordinate the work, and provide an infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day-to-day activities of the project. One of the first tasks that this host community organisation undertakes is to recruit a number of people from the target community to work on the project.

3. The Task or Tasks

The third key ingredient is the task or tasks that the community undertakes. According to the Centre for Ethnicity and Health model, this must be action oriented. It should be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects have involved communities in undertaking a piece of research or a consultation exercise within their own communities. In some cases there has been an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme run on behalf of the DH, the process and its outcomes have equal importance. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn; awareness will be raised; stigma will be reduced; people will opportunities to volunteer and gain qualifications; new partnerships will be formed; and new workers will enter the workforce Besides, it is important not to lose sight of the fact that it will be the fist time that these individuals have undertaken a research project.

4. Supports and Guidance

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate support and guidance. It is not expected that community groups offer their time and input for free. Typically a payment in the region of £15-20,000 will be made available to the host organisation. It is expected that the bulk of this money will be used to pay people from the target community as community researchers[2]. A named member of staff from the community engagement team is allocated as a project support worker. This person will visit the project for at least half a day once a fortnight. It is their role to support and guide the host organisation

[1] The target community may be defined in a number of ways – in many of the community engagement projects it has been defined by ethnicity. We have also worked with projects where it has been defined by some other criteria, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. users of drug services or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with (e.g. victims of domestic violence, sex workers).

[2] This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

and the researchers throughout the project. The University also provides a package of training, typically in the form of a series of accredited workshops.

The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to form an appropriate steering group to support the project[3].

The steering group is an essential element of the project: it helps the community researchers to identify the community they are engaging with, and can also facilitate the long term sustainability of the projects recommendations and outcomes. The community researchers undertake a needs assessment or a consultation exercise. However the steering group will ensure that the work that the group undertakes sits with local priorities and strategies; also that there is a mechanism for picking up the findings and recommendations identified by the research. The steering group can also support individuals' career development as they progress through the project

The UCLan community engagement team

The Centre for Ethnicity and Health has a large and experienced community engagement team to support the work. The team comprises of two programme directors, senior support workers, support workers, teaching and learning staff, an administration team and a communications officer. They work across a range of community engagement areas of specialisation, within a tight regional framework.

<table>
<tr><td colspan="4">National Programme Directors</td></tr>
<tr><td colspan="2">Northern Team | Midlands Team</td><td>Southern Team</td><td rowspan="2">Senior Programme Advisors</td></tr>
<tr><td colspan="2">Senior Support Worker</td><td>Senior Support Worker</td></tr>
<tr><td>Support Workers</td><td rowspan="2">Support Workers</td><td rowspan="2">Support Workers</td><td>Drug Interventions Programme</td></tr>
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<tr><td colspan="4">Teaching And Learning Team</td></tr>
<tr><td colspan="4">Administration Team</td></tr>
<tr><td colspan="4">Communications Officer</td></tr>
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Programme outcomes

Each group involved in the Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community. The qualitative themes that emerge from the reports are often very powerful. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

In 2005/-6 the Substance Misuse Community Engagement Programme was externally evaluated. This concluded that:

[3] Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

- The Community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.

- The Community Engagement Programme had enabled many new networks and professional relationships to be formed and that DATs appreciated the links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.
- most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.
- all DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.
- A significant number of the links established between DATs and community organisations as part of the Community Engagement Programme were made for the first time.
- The majority of community organisations reported their influence over commissioners had improved.
- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.
- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme.
- The vast majority of participants and stakeholders expressed high levels of satisfaction with the project.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

The views expressed in the report are those of the group that undertook the work, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire.

Purpose and Scope of the Project

The main aim of the research was to:

Identify the extent and nature of post traumatic stress within the Somali community in Northampton and assess the extent to which existing services and sources of help were meeting their needs.

The objectives were as follows:

1. To target those in the Somali community who may have experienced post traumatic stress disorder and general mental health problems.

2. Explore the barriers and problems people faced and the types and extent of impact that post traumatic stress and mental health had on both individuals and the Somali community as a whole.

3. The views and concerns expressed by the Somali community about post traumatic stress and mental health.

4. Whether the existing mental health services and agencies were accessible to those who needed their help.

5. How those who needed these services could access them.

6. Establish the level of mental health problems and trauma in the community and how these issues were seen in the community and the level of the service available to them.

7. Establish what impact the above issues were having on individuals as well as the community concerned (i.e. the Somali community in Northampton).

8. Identify the barriers facing Somalis when using mental health services.

9. Identify appropriate and effective ways to help these groups or community.

10. Learn about the social dynamics and perceptions of the target group, problems and solutions.

11. Make recommendations to service providers and commissioners to improve mental health services for the Somali community.

The Background of Northamptonshire Somali Community

Arrival and Settlement in Northamptonshire

The Somali Community is one of the newest communities to settle in Northamptonshire. Somalis come from the Eastern African region known as the Horn of Africa. Somalia is a peninsula of 637,140 square kilometres. The last official census taken in 1987 estimated the Somali population at 6,590,325. The people of Somalia are called Somalis (occasionally Somalians) and the official language is Somali. (National census survey 1987 Ministry of planning and National heritage)

The last eighteen years of Somali history has been tragic. A military regime led by General Siad Barre took power in Somalia in October 1969 and ruled the country for 21 years. The difficult socio-political conditions created by the regime and repression against opponents forced many to flee the country. In the late 1970s through the 1980s armed groups were founded, fighting to oust the regime.

The struggle gained strength and culminated in January 1991 with the overthrow of the Barre regime. Unfortunately, the clan-based factions who succeeded Barre were unable to form a government of national unity. The country disintegrated into anarchy and civil war. Over one million Somalis fled the country seeking protection in countries around the world. Most ended up in refugee camps in neighbouring countries, but significant portions were accepted as refugees in countries outside the region, particularly in Europe, North America and Australia and New Zealand.

Hundreds of thousands died as a consequence of the war. Today, Somalia is still without a recognised national government. An interim form of government backed by the UN has been formed but has no teeth to govern most part of the country.

The majority of Somalis arrived and settled in Northampton during the last 10 years. Only a few Somalis lived in Northampton in 1995 and onwards; this number went up to 3500 by June 2007 (NBC housing and money advice RS 2006/2007). Today, the size of the Somali Community in Northampton is estimated at between 3,500 and 4000. Somalis live across Northampton with a high concentration in council housing. Most Somali work in local industries in Northampton.

Many Somali in Northamptonshire have lived through trauma, physical atrocity and have seen the loss of loved ones in the civil war. Overnight, a great number lost their properties and wealth and had to spend prolonged periods of harsh life in refugee camps in Africa before coming to the UK.

Somalis often feel great relief on arrival in Northampton as it marks the end of their nightmare of persecution and torture. However, happiness is often short lived, because, in spite of the feeling of safety and the satisfaction of arriving in a country where they had their immediate needs met, they found themselves confronted with a host of cultural and other barriers. Uncertainty for their own future and concern for the safety and well-being of families back home, are continuing stress factors for many in their new environment.

Religion:

Somalis are 98% Muslim. Islam plays an important role in their culture and way of life. Community members congregate in mosques and observe Islamic festivities. Somali cultural life reflects some remnants of pre-Islamic traditions that have become inextricably interwoven with the concepts and beliefs of Islam; such aspects are also present in the health practices of Somalis.

Family:

Traditionally, the father heads up the family where everyone has a specific role. Care of the children is primarily the responsibility of the women though in practice

everyone contributes to their care including older siblings, other relatives, family friends, and neighbours.

Somalis love children, with the dream of every couple to have several children. The fertility rate in Somalia was estimated at 6.76 children born per woman in 1997. (WHO country report 1999) This is significantly higher than that of the mainstream. In Northamptonshire, due to affordability and availability in size of accommodations, Somali families often live in overcrowded conditions. Seniors are highly respected, live with or are cared for by their offspring. Somalis keep in close contact with their extended families. Everyone is expected to support members of his/her kin; likewise everyone can expect support from relatives. Physical and sexual abuse of children is not known in Somali society.

Health Practices:

The concepts of health and disease are based on a mixture of Muslim and traditional Somali beliefs. Overall, Somalis believe that illness and healing occur only by the will of God (Allah).

This creates a particular attitude towards illness. Suffering from a disease is not seen as totally negative. It has a positive side to it: forgiveness of one's sins by God. Disease is accepted and the condition is to be borne with dignity. Complaining too much about ill health is seen as inappropriate and poor behaviour (Abdi abdirahman mental health for Somali community Northampton 2005). All minor ailments are not perceived as illness. Culturally a person is either sick or in good health. A sick person is never left alone. Hospital bedsides are often crowded by relatives, friends, neighbours and other well-wishers. In Somalia, doctors do not deal with the patient alone but with the family. The family is always part of all-important decisions.

Traditional medicine:

Traditional healing has been practiced in Somalia since time immemorial. It is still today the only medical care accessible to the vast majority living in rural areas. Even in the cities, traditional healing practices have a prominent role. Trained medical physicians may be consulted only if the traditional medical practitioner fails in his/her performance.

Though ultimately every illness occurs under God's will, some diseases are thought to be caused by other people or by spirits. Very common among interpersonal diseases is the so-called "ill" (evil eye). A healthy or wealthy person may fall ill or have an accident because they were ‘evil-eyed’ (looked at) by a less lucky person. Other causes of disease are curses. Curses by ill treated or disregarded parents are among the most dreadful. Diseases can also be caused by witchcraft. A majority of Somalis also believe that some diseases are caused by spirits ("jinni” or "jinn").
The concept of communicable diseases is well understood and keeping of good hygiene is seen to be very important. The linkage between mosquito bites and malaria was well understood long before "modern" medicine discovered; Traditional methods of treatment are still used by Somalis alongside conventional medicine. Most common among these are Quranic readings, use of a wide variety of herbs, cauterization (applying a thin burning stick or metal on the affected part), scarification, fumigation and wearing of amulets. Surveys carried out in Somalia in the 1980s (Fahma Somali culture and mental health 1980) show a widespread use of traditional medical practices.

Mental health:

Traditional concepts hold that “jinn” mainly cause mental diseases. These may cause the affected person to see images or to hear voices that are not perceived by others. Minor mental disorders are often not perceived as health problems. The individual and his/her relatives do not detect them promptly. Abnormal behaviours, unless impressive, are not taken seriously and are often ignored. Concepts of stress and depression are not recognised in the traditional health care system. All of this may result in care seeking starting later and at a more serious stage in the problem. Normally a disease is accepted by the individual and the family as the will of God (Allah). This is very helpful as a way of coping with the illness' pain and distress with dignity and without having to recourse to desperate action. It is also an explanation as to why suicide is rare in Somalia. The main difference in people's behaviours towards physical and mental disorders is that mental disorders carry stigma and therefore are not easily accepted or may even be denied. However, the stigma never leads to ill treatment or abandonment. Families support relatives through all imaginable hardships.

As for care, medical attention is not always the first to be sought. One-to-one counselling with mental health professionals is not a cultural norm and thus not much sought after. Normally, counselling is done within the family or with community elders. Individuals are treated with Quranic readings, administration of herbs, fumigations etc. In some cases the "devil" is driven out by exorcism in procedures somewhat similar to practices in other religions. Also non-religious rites are practiced to drive spirits out by means of dances, songs, perfumes and fumigations. Notorious among such rites are "mingis", "saar", "borane" and "hayat"'.

Difficulty of life in Northamptonshire:

In Northampton, Somalis experience a variety of difficulties that tend to undermine their adaptive skills. Prominent among these difficulties are:

Language:

Not being proficient in English is the first barrier that prevents many Somalis fully integrating into English life. English proficiency has a significant relationship with positive social participation. In Somalia, the official language is Somali. While many educated people speak English when they arrive in UK, the majority does not have a good command or knowledge of either official language.

Weather:

Many Somalis have great difficulty with UK weather. Coming from a dry and warm land on the equator, Somalis have trouble adjusting to continuously changing weather conditions, the long cold winters, snow and rain. A significant number of people especially seniors and mothers with small children rarely venture outdoors during the winter months.

Family life:

Family ties are very important for Somalis. Traditionally, there is a two-way support between the individual and his extended family. Individual problems are normally solved collectively. Most of those living in Northampton have a part of their family in Somalia or abroad where they were forced to emigrate. Family separation is the cause of a lot of anxiety within both the individual and the community. An entire

welfare system based on family support is lost and is very hard to substitute.

During the civil war, many men were separated from their families; some were killed or imprisoned, others remained behind to defend their properties or for other reasons. A consequence of this has been that many Somali families in Northampton are formed on the basis of single mothers with children. Family life presents new challenges for all family members. Men previously were the breadwinners and had the leadership role in their families; they lost both roles. Unemployment, poverty and loss of status cause both stress and loss of self-esteem in a large number of Somali men. They feel powerless at home and outside in the community.

Women now carry three burdens, that of mother and being the breadwinner and leader of the family. At the same time they do not always enjoy the support of an extended family. Many have to play a new role, which they were not used to. Somali women experience a great deal of stress in raising and educating their children especially teenage boys. Single parent families are a rare exception in Somalia. Even when children live with one of the parents there are relatives who support the family and contribute to their education. Children and youth are confused by the dual culture they live in at home and outside in their schools. This may cause behavioural problems and learning difficulties in some Somali children. Children are constrained in their activities by space limitations at home, weather and concerns about safety in the community. There is an inter-generational gap between children and parents with children adapting fast to mainstream European culture, while adults hold onto their traditional one.

The problems faced by the younger generation may cause loss of self-esteem. Some youth go to jail for petty crimes. Some of them are reported to be abused during detention and come out with mental health problems. The problem is made all the more serious by the lack of rehabilitation programs for such youth.

The phenomenon of the so-called hyperactive children is new to most Somalis. A frequent complaint is that Somali children are labelled with this term. The reason for this has not been explained or studied. This creates a significant community problem with the school system. There is a strong feeling that all schools choose to send

Somali children for psychological assessment. In addition, some are seen as failing the assessment as a result of it being based on concepts alien to Somali culture. There is also a perception that a great number of children are ending up in special needs programs or ESOL classes. This includes English-born, English speaking children. The community sees stereotyping and discrimination based on culture and race as operating factors.

There is widespread community frustration with the way that UK social, educational and judicial systems interact with the traditional Somali family, in terms of values and parental roles and responsibilities. People would like to raise their children the way they were raised by their parents. However, this is seen as a dream for many. In discussions within the community it is common to hear comments such as:

"With all the talk about rights and freedoms, the UK system penalises parents by suppressing their right to raise their children the way they feel is the best."

"There is no respect for new immigrants' culture and feelings in order to align children with mainstream culture, the system is ready to alienate adult newcomers."

“It is too much change too fast"

"The worst thing that may happen to a father and mother is that the Government or social services takes away their children and gives them to others".

Employment:

The response from the community shows that majority of Somalis have temporary employments having difficulties to find permanent and secure jobs in Northampton. Unemployment is among the top-ranking problems encountered by Somalis. Although this time round unemployment affects women and youth. A study by Abdi Abdirahman (2005/2006) identified the following as the main barriers facing Somali professionals and trades people: lack of UK work experience; lack of information to available services; access barriers to educational upgrading and retraining; lack of centralised academic credential assessment services; lack of access to professional licensing; and lack of English language proficiency. Furthermore, people have

limited knowledge of the job market here. Even people with professional degrees from other European countries or the United States with valuable skills and work experience are unable to get employment because of the above reasons. Getting a job in one's own field is particularly difficult. Only 2% of Somali professionals and trades people are employed in their chosen fields. Many become caught in a cycle of depression, isolation and poverty.

Social integration:

Because of their unfamiliarity with the cultural and social norms of UK, Somalis appear to get less involved with members of the wider society. People generally feel less warmth and more formality in their own social relationships in Northampton. The culture is so much different from what they experienced at home. This makes the community inward looking and closed in on itself.

In Somali society, there are few, if any, class structures. People interact easily and without formality, regardless of their social position. People are used to dropping in on friends and neighbours without prior arrangement. In Somali society parents enjoy a lot of social interaction and get ready to help look after their children. In the UK and Northampton, parents (often single mothers) feel isolated, most of their time and energy being drawn to household chores and childcare. Isolation is a common theme frequently repeated by Somali mothers. The Somali community is confronted with new challenges and has difficulty in addressing the needs of individuals and families. Efforts are further hampered by a scarcity of resources.

Immigration policy:

UK immigration policy is viewed as highly stressful and penalising to the community. Most Somalis feel strongly disadvantaged and prevented from competing fairly with other newcomers. Somali asylum seekers are obliged to remain without legal status for five or more years unless they produce "proper identification documents" (Asylum team report 2007). However, many complain that they have genuine identification documents but immigration officers refuse to accept them.

There are many cases of people living and working in Northampton for more than five years or more without being granted the right to live permanently in the country.

This is characterised as discriminatory government policy directed to the community.

Racism/discrimination:

Our study on Somali refugees in Northampton showed that about 50% of respondents reported some form of social prejudice or discrimination because of their colour. The heavy presence of Somalis in certain neighbourhoods has occasionally generated racial tensions between Somalis and other groups. Experiences of discrimination were reported in other circumstances, such as in the application for housing and employment, as well as in the work place. Most of the time discriminatory incidents were not reported, as victims were unfamiliar with UK human rights legislation. Lack of access to information was a major barrier for many Somalis.

Concern about events in Somalia:

In the community there was ongoing concern about the situation in Somalia. The welfare of family, friends and others and the lack of peace and stability were causes for anxiety and feelings of powerlessness.

Loss of status:

Before the civil war many newcomers were financially well off and had properties and jobs. Educated people were practicing the profession they had been trained for and harboured good hope for the future. All this disappeared overnight. Being unfairly relegated to the lower strata of society has caused stress, anxiety and loss of self-esteem.

METHODS

The research consisted of a structured questionnaire based on the research focus. The interviews were conducted in Northampton mainly in areas that had high concentrations of Somalis and included the following areas: Kings Heath, St James, Spring Borough, The Mounts, Weston Favell and the Town Centre.

Before the interviews were conducted the project was introduced to the community through community organisations via the community leaders. Information was also passed to the community through leaflets, which were distributed, via local Somali shops, GP surgeries and Internet cafes frequented by Somalis and through the local press (The Chronicle and Echo). Members of the Somali community were invited to take part in the interviews and give their honest views and opinions.

The Northamptonshire Somali Community Association (NSCA) then recruited five research team members among the community to carry out the research. All of the researchers were voluntary community workers and showed great interest and enthusiasm during the course of the research. As community volunteers all of them had good links, sound working relationships and trust with the community.

The five researchers attended community based research training workshops, which were delivered by UCLan. In these training workshops the researchers were trained on research methodology and research skills; communication skills; research ethics; risk and safety assessment and management etc. Two of the workshops were focused on mental health and four were concerned with conducting research. The final one was an assessment workshop and only the members of the research team undertaking the qualification needed to attend this one.

The training workshops were very helpful to the research team as they introduced them to new ideas, knowledge and important information. After the training most of the research team acknowledged that they had very limited knowledge about mental health or post traumatic stress and that negative perception about the illness came to their mind when they thought about mental health or post traumatic stress. These

perceptions changed after the workshops.

Throughout this period UCLan supported the community research team through a Support Worker who provided guidance and advice to the researchers at all the stages of the research project. Despite poor attendance a Steering Group comprising of project supporters and key stakeholders also supported the researchers. The objective of the Steering Group was to: guide the team on the scope of the research; oversee ethical issues; ensure researchers were properly trained, the project was on schedule and a comprehensive report was completed on time. Finally, the Steering Group was needed to help develop an exit and follow up strategy on the recommendations.

Key members of the Steering Group included representatives from Northamptonshire Healthcare Trust, the local FIS lead, CSIP, Maple Access, Criminal Justice and UCLan Support Worker. Maple Access Partnership that provides substance misuse treatment helped the research team develop and design the questionnaire and gave their valuable expert advice. The Community Development Worker represented by the Service Development Manager, administered the research project and the local DAAT assigned one of their technical staff to help the researchers with data analysis.

The research co-ordinator represented the research team at Steering Group meetings and reported on progress. He provided feed back to the team suggestions, advice and recommendations made by the Steering Group. The NSCA Chairman was involved in the daily administration of the researchers and represented the community at Steering Group meetings. Other Somali organisations such as the Union of Somali Women were also represented at Steering Group meetings.

The researchers collectively designed the questionnaire that was to be used in interviewing members of the community with input from the Steering Group. A consultation process followed where members of the Steering Group the Support Worker and members of the Somali community scrutinised the questionnaire to check that the questionnaire properly covered all the areas that the research project was aiming to investigate. During this period the questionnaire went through a

number of revisions until a final version was produced upon final agreement. Finally, the questionnaire was sent to UCLan for ethical clearance.

The final Questionnaire contained ‘closed’ questions that respondents had to choose from. However, there were a number of questions that allowed respondents to give open answers about their views and concerns.

During the field work the researchers worked in pairs to ensure their safety. Two teams were formed and over a period of three weeks ninety-six individuals and one focus group discussion with professionals was held. On average the questionnaires took about an hour to administer with the researchers attempting to access a broad cross-section of the community who had experienced post traumatic stress, mental illness between the ages of 30 – 65. Once the fieldwork had been completed the data was inputted onto an Excel spreadsheet Three members of the research team undertook this work.

Results

Core Data

In total 92 participants were contacted:

- Semi-structured interviews 92
- Focus groups 4

Out of which:

- Female Participants 29
- Male Participants 47
- Preferred not say 16

When asked about their sexuality, 76 responded as heterosexual with 16 preferring not to say.

Table 2 illustrates the diversity of the sample and the distribution of male and female respondents. Although the male number is higher but there was fair representation of women (31%) in terms of responses that were received.

Table 3 illustrates country of birth. The results show 5% of respondants were born in the UK whilst 87% of respondent born outside.

Table 6 illustrates the diversity of languages spoken with Somali being the main mother tongue. Respondents that have resided in the UK for the last 5 years spoke fluent English whilst those who moved from other European countries also spoke Dutch, Danish, Swedish, Swahili Arabic and French.

1. Age last birthday

30-40	40-50	50+	Prefer not to say
43	18	15	16
46.7. %	19.5%	16.3%	17.3%

2. Gender

Male	Female	Transgendered Or Transsexual	Prefer not to say	TOTAL
47	29	0	16	92
51%	31.5%	0%	17.3%	99.8%

3. Were you born in the UK? If no, how long have you lived here?

Yes	No
5	87
5.43%	94.57%

Less than 1 year	1-5 years	6-10 years	11 years or more	No answer	Total
9	32	24	12	15	92
9.7%	34.7%	26%	13%	16.3%	99.7%

4. Employment status

Employed	Un-employed	Self-employed	Housewife/ Homemaker	Others	Total
33	27	7	22	3	92
35.8%	29.3%	7.6%	23.9%	3.2%	99.8%

5. Citizenship

British citizen	14	15.2%
Refugees	32	34.78%
Asylum seeker	16	17.3%
Other European Citizens	19	20.6%
No Status	6	6.5%
Others	5	5.4%
Total	92	

6. Reason for coming to the UK?

Flee civil war	40	43.4%
Better life	16	17.3%
Fear of persecution	24	26%
Family Reunion	7	7.6%
Born in Britain	5	5.4%

7. Experience of traumatic event in the UK or in Somalia?

Yes	**No**	**No answer**
51	23	18
55.4%	25%	19.5%

8. Where?

	Yes	**No**	**No answer**
Somalia	47	12	33
	51%	13%	35.8%
UK	24	15	53
	26 %	16%	57.6%

9. Have you lost family members during the war in Somalia?

Yes	**No**	**No answer**
53	29	10
57.6%	31.5%	10.8%

10. Did this affect your mental health emotional well being?

Yes	No	No answer
53	21	18
57.6%	22.8%	19.5%

11. If yes did you seek any help for this?

Yes	No	No answer
10	35	8
18%	66. %	15%

Section two: Awareness of Post Traumatic Stress Disorder (PSTD)

1. What is your understanding of post traumatic stress syndrome?

Don't know	Understand & Gave reasons	Didn't wish to answer
48	18	26
52.1%	19.5%	28.2%

14. Have you been diagnosed with post traumatic stress syndrome?

Yes	No	No Answer
18	48	26
19.5%	52.1%	28.2%

15. If no, do you think you might be suffering from post traumatic stress disorder?

Yes	No	No answer
19	17	12
39.5 %	35.4 %	25 %

16. Did you experience any barriers/problems whilst seeking help for PTSD?

Yes	No	No answer
23	27	42
25%	29.3%	45.6%

17. Do/ did you receive any treatments?

Yes	No	No answer
27	46	19
29.3%	50%	20.6%

18. Were you happy with the treatment you received?

27 responses given

Yes	No	No Answer
13	8	6
48.1%	29.6%	22.2%

Section Three: Awareness of mental health

19. Do you think Khat or substance misuse has any effect on mental health?

Yes	No	No answer
55	35	2
59.7%	38%	2.1%

If yes please explain why:

18 comments were received - below being a representative example.

"Alcohol has effect on the person drinking and that will last up to 6 to 7 hours, but Khat makes the person sleep for more than three day or even more."

1. Most of the comments received were about khat and the effect it had on the community.
2. Abuses related to khat which also sometimes make the consumer very paranoid and abusive hence end up as domestic violence.

20. Do you think Alcohol has any effect on mental health?

Yes	**No**	**No Answer**
43	46	3
46.7%	50%	3.2%

21. Do you have any experience of mental health or PTSD

If yes, is it,

Personal	16	17.3%
Family	34	36.9%
Friends from the Somali community	31	33.6%
Other	11	11.9%

22 Did you/ they seek any help or advice

Yes	No	No answer
25	48	19
27.1%	52.1%	20.6%

23 How would you rate the help/advice, you/they received

25 responses given

Poor	OK	Good	Very Good	No Answer
12	5	3	3	2
48%	20%	12%	12%	8%

Please add comment on which service, and why you felt this way

Responses given:

"Poor G.P reception and so much egos they think that if you come to them you may harm them or do something to them."

"Lack of cultural understanding especially the GP's"

"You know if I am treated fairly or unfairly doesn't make any difference at the end of the day my family treat me with dignity"

"Lack of understanding and poor cooperation from the G.P staffs"

" Whether the service is poor or perfect I care less, what I know is mean't for such class of people, and it doesn't meet our needs so what is the point of rating"

"Accessing the service was like a hell but now through community workers, I am now in a position to have as good access than nine month ago"

24. Do you feel you/they were treated fairly?

62 responses received to this question

Yes	No	No Answer
14	36	12
22.5%	58%	19.3%

25. If No, do you feel that it was because of; (please tick more than one if applicable) *39 responses given*

Age	Gender	Cultural background	Other	No Answer
4	9	14	7	5
10.2%	23%	35.8%	17.9%	12.8%

Section four: Awareness of Services

26. Would you feel comfortable asking for help if you had mental health issues/ PSTD problems?

Yes	No	No Answer
18	**23**	**51**
19.5%	**25%**	**55.4%**

If No, please explain why: *6 comments* received many of them similar

"Because it is a shame to me individual/family''.

"Some people might label you as crazy"

"*They might detain me against my will*"

27. If yes, whom would you go to for help?

General Practitioner	Family	Community leaders	Mental Health Charities	Imam or spiritual leader	Other NHS services	No answer
12	**26**	**16**	**5**	**18**	**13**	**2**
13%	**28.2%**	**17.3 %**	**5.4%**	**19.5%**	**14.1%**	**2.1%**

28. Are you aware of services that are available to help you with mental health problems/ PTSD?

Yes	No	No Answer
37	42	13
40.2%	45.6%	14.1%

If yes, please list below:

There were 62 responses to this question, each shown as percentages of those answers.

General Practitioner	17	27.4%
Campbell house	23	37%
Community support workers	8	12.9%
MIND	7	11.2%
Community mental health team	2	3.2%
NHS	5	8%

29. Have you accessed any services for mental health issues/ PSTD

Yes	No	No Answer
25	42	25
27.1%	45.6%	27.1%

30. If yes, please state which and state why you rate it at that level

SERVICE	Poor	Ok	Good	Very good	Comments
Princess Marina Hospital Northampton	3	1	1	Nil	Nil
Campbell House Northampton *(Community mental health centre)*		3	12	Nil	"Staff"
Maple Access	2	2	Nil	1	
Welland centre Kettering	1				

31. Have you ever been treated unfairly whilst accessing a mental health service?

Yes	No	Didn't Answer
12	5	75
13 %	5.4%	81.5%

32. Do you feel that being Somalian made any difference to the care you received?

73 responses given

Yes	No	No Answer
29	13	31
39.7%	17.8%	42.4%

33. If yes was it positive/negative

Positive	Negative	No Answer
5	22	2
17.2%	75.8%	6.8%

34. Do you think that mental health services could be improved for Somali people living in Northamptonshire?

Yes	No	No Answer
67	5	20
72.8%	5.4%	21.7%

35. If Yes, how can services be improved: Please explain

There were 67 comments made which contained 3 common areas as detailed below,

Cultural issues	General	Awareness
25	20	22
37.3%	29.8%	32.8%

Focus Group Discussions

Profile of focus groups

Four focus groups were carried out across the four locations, reaching another 15 people:

	Male	Female	Total
Abington Area	16	11	27
Blackthorn	15	10	25
Kingsheath	14	9	23

Spring Boroughs	7	12	19

The methodology for convening the focus groups was similar to that used for the interviews but with co-facilitation in all cases between the Somali community leaders, the research team staff and community interactors. All focus four groups had interpreting services provided. Some chose to speak in English, some via their interpreter. The focus group discussions were not taped as participants felt uncomfortable with this. In these cases the facilitator took full notes. The focus groups were semi-structured and focused on usage patterns and attitudes to mental health and post traumatic disorder (both personal and community), awareness of services, other linked issues for the communities and possible solutions.

Profile of professional consultation

One discussion group was carried out with professionals working in mental health and related services and with religious leaders from the Somali community. Because in Northampton there are few Somali professionals it was decided to invite them from other areas.

Names	Area from	Organisation	Role
Ahmed Imaan	Manchester	Sheltered housing	CDW
Habiba Hassan	Tower Hamlet	British Somali foundation	Outreach worker
Farhiya Ismail	Northampton	PMH	Community nurse/ care support worker
Mohamed Haikal	Bromley	Somali centre	Community support worker
Abdirahman Fareh	Southall	Ealing hospital	Psychiatrist nurse
Dr.Hussein Abdullah Dukale	Birmingham	Birmingham University	Student from Canada
Sh.Ahmed Abdikadir	Religious leader	Woolwich mosque	Spiritual and community leader
HassanAw Aadan	Harrow, west London	Horn Africa Association	Mental health advocate
Hawa Abdikadir	Brent London	Somali women	CDW/centre manager

		refuge	

This discussion group raised issues about service use levels, cultural competence, needs assessment and more effective intervention models.

Discussions of results

The research has found that most Somalis living in Northampton have experienced traumas of war and conflict which has left many of them in a state of shock and mental distress which is further compounded by the process of migration and adjustment to a new culture.

Out of the 92 people interviewed 35.8% were in employment and 32% were refugees. 43.4% of the community fled civil war and 55.4% have experienced trauma in their native country and in the UK. It was also found that 57.6% of the community had lost family members. 57.6% of the respondents said their emotional wellbeing had been affected. Out of 92 respondents 33.6% did not seek any help due to language and bureaucratic barriers, mistrust of the system, lack of interpreters and unfamiliarity with provision of such services. Out of 92 people interviewed 52.1% did not know the understanding of Post-traumatic Stress Syndrome although many were sufferers. It was also apparent that people suffering from mental health were not being supported and infact were being stigmatised in the community resulting in many sufferers hiding their problems. 50% of sufferers did not receive any treatment - 29% did but all of them were not happy with their treatment.

Out of 92 people interviewed, 59.7% believed that Khat and substance misuse had an effect on their mental health. 43% said alcohol affected their mental health and worsened their mental state. 27% of the community associated stress with mental health illness, 22% depression and 15% anxiety. 33% of the people interviewed said they had family and friends who had experienced mental ill health and Post traumatic stress disorder PTSD

See a sample of the comments received comments below.

"Poor G.P reception and so much egos they think that if you come to them you may harm them or do something to them."

"Lack of cultural understanding."

"You know if I am treated fairly or unfairly doesn't make any difference at the end of the day my family treat me with dignity"

"Lack of understanding and poor in cooperation from the staff"

" Whether the service is poor or perfect I care less, what I know is mean't for such class of people, and it doesn't meet our needs so what is the point of rating"

"Accessing the service was like a hell but now through community workers, I am now in a position to have as good access than nine month ago ".

In terms of treatment when asked if they felt they had been treated fairly, 58% didn't think they had been treated fairly whilst 35.8% stated this was due to their cultural background.

"When you book an appointment with GP they look at your language and automatically they answer is we can't book you today"

"You are not given a chance to speak or express your problem because the staff or the doctors are not patient even the doctors"

"My doctor make comment about where I came from e.g. in you country do you have healthcare or good hospital back home which is out discussion in first place"

Out of the 92 respondents 66% felt comfortable to ask for help if they had a mental health issue. 28% said they would seek help from their family whilst 19% said from the Imam or spiritual leader (as the community uses Quran and traditional reading

as coping mechanisms).

42% said they were not aware of services available to help them with their mental health or Post traumatic stress disorder (PTSD) whilst 42% said they had not accessed any service:

"Even if I am mentally ill I will not access the services because I know they will treat me badly the system is horrible."

22% felt they were treated unfairly while accessing mental health services. 16% belived it was due to their cultural background. 39% felt it made a diffrence to care they received if they were Somali. 72% felt that mental health services could be improved for the Somali community in Northamptonshire. 25% felt that the community needed culturally competent community workers and more Somali professionals. Three common areas of concern included: cultural issues, general needs and more awareness and responsive services.

Adults and youth both reported high stress levels related to their employment, education and immigration status. After years of being here many still felt they were refugees.

After having endured hardship in their homeland and in refugee camps many Somalis arrive with a variety of health problems however after settling in Northampton their physical health does improve due to improved diet, nutrition and care but their mental health remains problematic due to post-traumatic stress disorder..

The research has indicated that most respondent didn't know of the terminology: Post traumatic stress disorder.

RECOMMENDATIONS

Mainstream service solutions

This research has identified a need to put into effect various measures that can be aimed at the prevention of mental ill health and problems and at improving access to mental health services that would benefit the Somali community. Implementation of recommendations found in the report will require funding resources as well as the cooperation of different institutions and community agencies. Most of the recommendations are directed to community organisations, Commissioners, Northamptonshire Healthcare Trust and the voluntary sector.

A) ***Cultural competence of services***

1. Employ Somali volunteers within services in visible roles and with supported routes into mainstream jobs.
2. Support umbrella BME advocacy services and forums to take a lead on policy and service improvement,
3. Wherever possible establish partnerships with local BME community associations.
4. And finally consider where there is community support for such an initiative, helping Somali communities to find rooms and imams for their own communal prayer, and in the long run combine support for training of local Somali imams with education, advice and counselling about mental health.

B) Advocacy and Public Education

1. A mental health education and awareness programme for the Somali community be developed and implemented.
2. A Somali resource and consultation service be established with the goal of assisting mental health service providers.

3. Improve access to mental health services and programme delivery.
4. That a Somali community organisation and Healthcare Trust develop and implement an advocacy strategy with the goal of creating community awareness and empowerment in the area of mental health services.
5. That community mental health workers be recruited, to provide outreach services to the Somali community.
6. That closer links and cooperation be established between Somali community organisations and mental health service agencies.
7. That ethno-specific Somali mental health workers be recruited to positions within the mental health service.
8. That ethno-specific support services in the areas of residential/recreational facilities, vocational training and rehabilitation be established with the goal of targeting Somali mental health service users.
9. That treatment models for mental illness be developed that reflect traditional Somali values, beliefs and practices research.
10. As people of ages 30+ were targeted people for this research it is recommended that children's mental health research project be developed to investigate the mental health needs of children within the Somali community.

C) Service Development

Cooperation between Somali community agencies and mental health institutions, as well as formal and informal networking among mental health service providers, community health workers and Somali community organisations needs to be established. All partners should develop methods of collaboration, each drawing from their respective areas of experience and strength. Cooperation among mainstream agencies on joint projects for the delivery of culturally appropriate services would have a positive impact on the capacity of health institutions to respond to the mental health needs of the community.

D) Health Promotion Strategies

Given the many barriers of access to mental health services the development of health promotion strategies should play a vital role in preventing mental health problems.

The way of defining mental health is different in different communities. Health promotion strategies should be ethno-specific for cultural and language reasons and should aim to empower the community. Health promotion was considered very important in the discussions generated by within this research because of its preventive rather than reactive approach to problem solving. Suggested strategies include:

(a) Community education
(b) Training of front-line service providers (mental and non-mental health systems).

Community based solutions

1. That the Somali community organisations and community health workers develop and implement an Advocacy strategy with the goal of creating community awareness and empowerment in the area of mental health Service.
2. That community organisations and leaders put in place mechanism to liaise with the government to address immigration issues affecting Somali refugees – restrictions be amended to allow for a more expeditious granting of legal status and family reunification.
3. That community support programmes be developed that provide emotional and financial support to Somali families caring for the mentally ill or advice and support bureau be established.

Reflection

"…This project was turning point for me , listening to the horror and difficulties that this people went through reminds me of how Somali community are so resilient to hardship but what keeps them well is the determinations and the faith but that in mined still there is a need that their fate be addressed "

Abdirahman *(Community researcher)*

"I have learnt a lot through this project, myself I was scared about the project but now the skill and the knowledge I had through have made me successful community support worker".

Barlin Haili.

Towards the final stages of the project, whilst writing up the themes the researchers highlighted the need for the NHS to change its framework and not solely to rely upon and work with the medical model. This was also illustrated via the semi-structured interviews which again reaffirmed the need for culturally competent services and for this to be made available at first point of contact and not an add-on.

The project has equipped the researchers with skills such as listening, supporting, building individuals confidence and self esteem while being non-judgemental, but above all to believe in someone's ability and help them achieve their goal whatever that maybe i.e. reduction of stigma, active roles within their family and community.

Some participants became aware of services available to them through Northamptonshire Somali community association and that there is alternative support available. This was positive as many individuals felt that they did not have to primarily rely on services in the future.

The researchers and community leader's, workers feel that immediate action be taken to address mental health problems in the community, as this switched the light on for Somali community researchers and community leaders

There five researchers involved in presentations and chairing steering group meetings, upon reflecting on this others highlighted that they would like to pursue or would be happy to partake in further practise or training in mental health, presentations and chairing meetings.

The team of researchers and workers expressed commitment to the project and would like to see the report being implemented within the policy and/or practises of the primary services, NHS and PCT's. It was hoped by the research team that a year long project and the wealth of information obtained, the time and effort they have undergone not go to waste and for this to become "another project". Finally the researchers have expressed that they would like to remain as volunteers and learn more about the ethos and framework that NSCA works with.

Overall what was unanimous was the belief and passion in which the research was conducted and carried out in order to improve services for the betterment of one particular community, however findings show the importance of faith based approaches which could result in the betterment for other community and faith groups.

Appendices

Appendix 1

Northamptonshire Somali community

NIMHE community engagement programme

Information sheet-

What the project is about

The project intends to carry out research into the extent and nature of post traumatic stress within Somali community in Northampton and assess the extent to which existing services and sources of help are meeting the needs of the community appropriately. We hope to make recommendations to service providers and commissioners to improve mental health services for Somali community.

The research has been commissioned by the Care Service Improvement Partnership (CSIP) and is managed by Northamptonshire Somali community, and supported by university of central Lancashire.

What am I being asked to do?

You are being asked to take part in interview, which will take about an hour. We will ask you some questions about your own experience of trauma, how you have coped and about service that you might like to see developed.

Taking part is voluntary

Your participation is completely voluntary. You do not to answer any questions if you do not wish to and you may stop the interview at any time if you not wish to continue.

What will happen to the information given?

The information you provide will be stored securely at our office, then the information will be analysed and produced into a report. Once the report has been produce, all original data paper will be destroyed. The report will be used to inform the health service professionals, and those commissioning mental health services on how to

improve services for Somalian community.

Confidentiality

No names or address will appear either on the questionnaires or in the final report. The report will be anonymised.

All information' will remain anonymous and confidential, unless you give us information which suggest the either you or someone else May be at risk serious harm, including child abuse/child protection issues.

Do you give consent to proceed with interview? Yes/No

Thank you

Northamptonshire Somali community

NIMHE community engagement programme

Appendix 2

Questionnaire:

All information is confidential

***Please answer, as many questions as you can*, <u>there are no right or wrong answers:</u>**

Male □ Female □

First part of postcode (e.g. NN1) ----------

1. When did you move to UK? 19____

2. How long have you lived in Northamptonshire? _____ Years

3. What is your occupation?

Employed □ unemployed□ self-employed□

Housewife (homemaker) □

4.What is your immigration status?

Citizen □ indefinite leave to remain □other □European citizens □

asylum seeker □ no status □

5.What made you come to the UK?

6.What traumatic events have you experienced?

7.Have you lost family members during the war in Somali?

8.What effect did the war have on your health?

9. Tell us about what you know about PTSD?

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10. What traumatic events have you experienced?

11.What kind of help have you received to assist you in dealing with Post traumatic stress disorder?

12.What barriers have you experienced in seeking help for PTSD?

13. Do you receive any treatments?

14. How would you rate the treatment you received? *(Please tick one box)*

(**Please add comment on which service, and why you felt this way)**

SERVICE	Poor	Ok	Good	Very good	Comments

15. Do you feel you were treated fairly? Yes □ No □

16. If No, why do feel that you weren't treated fairly (please tick any that apply)

Age □ Gender □ Cultural background □

Other □ (please describe)

17. Do you feel that being Somalian made any difference to the care you received?

Yes □ No □

If yes, was it positive □ negative □

18. What is your understanding of "PTSD" (Please use your Own words)

19. Please list any mental illnesses you have heard of?

20. Do you think Khat or substance misuse, has any effect on mental health?

Yes □ No □

If yes please describe

21. Do you think Alcohol has any effect on mental health?

22. Do you have any experience of mental health or PSTD?

Yes □ No □

If yes, is it;

Personal? □

Family? □

Friends from the Somali community? □

Other □

23. Did you/they receive any help or advice?

Yes □ **where (please state)**

No □ **Why (Please state)**

24.How would you rate the help/advice, you/they received; (please tick one box)

Poor □ **OK** □ **Good** □ **Very good** □
Don't know □

(**Please add comment on which service, and why you felt this way)**

25. Do you feel you/they were treated the way the needed?
Yes □ **No** □

If No, do you feel that it was because; (please tick any that apply)

Age □ **Gender** □ **Cultural background** □

Other □ **(please describe)**

26. Do you think that mental health problems occur more often among Somalis here in Northampton against people living in Somalia?
More often here □

About the same □

More often in Somalia □

No opinion □

27.Do you know where to get help or advice regarding mental health?

Yes □ No □

If yes, please say where

28.Would you feel comfortable asking for help? Yes □ No □

If No, please try to describe why. (in your own words)

29.Whom would you go to for help?

30. Do you think that Health services could be improved for Somali people living in Northamptonshire?
Yes □ No □

If Yes, How could this is done? (Please describe)

31. Has the war in Somalia had any impact on you is this/ them as a whole, or on there mental health

Yes □ No □

If yes (please describe in your own words)

Thank you for your help in completing this questionnaire

If you need any help, assistance or advice with this, please feel free to contact us at the number or address below;

Our contact details are:

Abdirahman, Qadra, Barlin, Abdullahi or Abade, on,

Abdirahman - 079 32253021
Email: askwehelp@yahoo.co.uk

Abade - 0794 7908936
Email: Abade68@hotmail.com

C/o Northamptonshire volunteering centre
15 St Giles street Northampton NN1 2AA

Appendix 3

Delivering Race Equality Programme
The brief history of DRE

Delivering Race Equality in Mental Health Care (DRE) is an action plan for achieving equality and tackling discrimination in mental health services in England for all people of Black and minority ethnic (BME) status, including those of Irish or Mediterranean origin and east European migrants.It draws on three key recent publications in particular:

1. Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England;
2. Delivering Race Equality: A Framework for Action; and the independent inquiry into the death of David Bennett (although DRE itself is not a direct response to the inquiry's report).
3. David Bennett was a 38-year-old African-Caribbean patient who died on 30 October 1998 in a medium secure psychiatric unit after being restrained by staff. As well as DRE, this document contains the Government's formal response to all the recommendations made in the report of the inquiry into David Bennett's death. The responses are overwhelmingly positive and, taken together with the action plan in DRE, comprise a coherent programme of work for achieving equality of access, experience and outcomes for BME mental health service users.

The programme is based on three 'building blocks', first proposed in the consultation version of DRE:

More appropriate and responsive services – achieved through action to develop organizations and the workforce, to improve clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees, and

children;

Community engagement – delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers; and

Better information – from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services. This will include a new regular census of mental health patients.

Delivering race equality in mental health care

DRE itself is just one component of a wider programme of action bringing about equality in health and social care. For example, National Standards, Local Action is the Department's current care standards and planning framework. Among the core standards that it sets out are:

- That healthcare organisation must challenge discrimination, promote equality and respect human rights (C7 (e)); and that organisations must enable all members of the population to access services equally (C18).
- DRE will support the implementation of Sir Nigel Crisp's 10-point race equality action plan in the NHS, and will also help NHS trusts to fulfil their obligations under the Race Relations (Amendment) Act 2000.

The vision for DRE is that by 2010 there will be a service characterised by:

- Less fear of mental health services among BME communities and service users;
- Increased satisfaction with services.
- A reduction in the rate of admission of people from BME communities to psychiatric inpatient units.
- A reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units.
- Fewer violent incidents that are secondary to inadequate treatment of mental

illness;

- A reduction in the use of seclusion in BME groups;

- The prevention of deaths in mental health services following physical intervention.
- More BME service users reaching self-reported states of recovery;.
- A reduction in the ethnic disparities found in prison populations;.
- A more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;.
- A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and
- A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

Implementation of DRE should be a matter for everyone involved in planning, managing or delivering mental health care. Focused implementation sites will be established to help identify and spread best practice.

Community engagement -What is it and why is it important?

While community engagement as a concept has been around for many years, there is no common or widely agreed definition of it. Recently the Pacesetters programme came up with a framework for effective community engagement,

However in this context when we talk of ‘community engagement’, we believe that:

Community engagement is built on the principles of equality and social justice.

It acknowledges that barriers to healthcare services exist for many people and that those barriers are often rooted in the failure of agencies to recognise adequately the complex social, cultural, religious, economic and generational experiences of some distinct communities.

It further recognises that within some communities there is a lack of awareness and knowledge around a range of health and social care issues and services.

Stigma and denial exist around some of these issues (e.g. substance abuse and mental health) and within some communities.

Community engagement takes as its starting point the premise that the community itself has the greatest ability to access its own members in order to raise awareness and assess need, and that agencies have the responsibility to develop services to meet that need. However, the complete body of knowledge required to identify the needs of all people, raise awareness on a range of health and social care issues, educate and disseminate information does not lay wholly with the community or with the agencies. Hence, creating an environment where communities and agencies can share that knowledge will fill the gaps.

In a nutshell, community engagement provides benefits to the public, to patients and service users, to staff, to the NHS and UK plc as a whole.

Appendix 4

Principles of the research

During the research, those involved were strongly advised to oversee and adhere to the following principles:

1. Comply with the data protection act.
2. Respect diversity and peoples cultures, individuality and attitudes.
3. Not to influence by any means, knowingly, the process of the research.
4. Protect strictly the confidentiality of respondents.
5. Treat individuals with respect.
6. Involve all stakeholders and inform them of the findings of the research.

The research also comprised two strands:

Structured confidential interviews with Somali community members whom some of them experienced PSTD; no respondent was asked his/her name or address. However, interviews took place in community settings in Northampton.

Discussions and structured interviews with key statutory and voluntary-sectors Professionals whom most of them were Somali

Northamptonshire Somali Community Association

APPENDIX – PUBLIC NOTICE

PUBLIC NOTICE

Northamptonshire Somali Community Association (NSCA) would like to inform all the Somali community members in Northampton that a community engagement project research on post traumatic stress within Somali community in Northampton, commissioned by care services improvement partnership and funded by the Department of Health would be conducted by a research group from the community.

The research group have been trained and is supported by University of Central Lancashire through community support worker. This particular research project will mainly focus on the extent and nature of post traumatic stress disorders among the Somali community in Northamptonshire. The research project is aimed at finding out the views of the community exploring the barriers and problems faced and types and extents of impact that post traumatic stress disorder and general mental health is having on individuals and Somali community as a whole was the main motives for the research.

Through this research, it is expected that the mental health services will be able to provided the appropriate treatment and interventions according to the findings identified.

Northamptonshire Somali Community Association would like to encourage all the Somali community members to participate in this worthy project whose outcome we hope will be of great benefit to the community. For more information regarding the Project please contact the research project co-coordinator-Abdirahman Abdi

References

1. Bernard Guerin, Omar Roda. Somali conceptual and expectations concerning mental health 2004.
2. Abdi abdirahman. Mental health needs for Somali community in Northamptonshire 2005
3. Delivering race equality in mental health care (an action plan for reform) DH 2005.
4. Ministry of planning and national heritage (National census 1987) www.hiiraan.com .
5. Northampton borough Council housing and money advice resource centre 2006/2007.
6. World health organisation (WHO) country report (Somalia) 1999
7. Fahma Somali culture and mental health 1980.

For further reading please see below report

Community engagement and substance misuse khat report 2005