

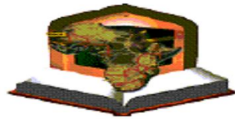
Community Engagement Project

NIMHE Mental Health Programme

Report of the Community-Led Research Project Focusing On

The Mental Health Needs of Somali 11 to 18 Year Olds In Bristol

**Amana and Transparency Research Partners Ltd
on behalf of and with the Somali Community in Bristol**



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to

Bristol City Council and PCT joint commissioners of services for Emotional health and Wellbeing

Community Engagement Project

Mental Health Needs of Somali 11 to 18 Year Olds in Bristol

1 Research Team

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

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Known as Mumin to the Somali community in Bristol, Mumin has lived in Bristol for five years with his wife and children. He is passionate about trying to resolve the unmet needs of the Somali community, particularly the educational needs of the Somali young people. He works part time in an inner city secondary school and also volunteers for Amana. While taking part in this research he has also developed links with other schools. Mumin's involvement in this project is through Amana and he agreed to be a researcher in order to gain some understanding of the emotional needs of Somali children.

Ismhan Abdisamad Hussein

Ismham is 24 years old. She has lived in Bristol for two years. Since moving to Bristol she has been a volunteer with different Somali community groups including a women's group and Amana. Whilst at Amana she has taught Islamic culture and is planning to pursue a career in primary teaching. She took part in this research to with the aim of making things better for the young Somali children through community support.

Abdirahman Ahmed

Known as Bool to the Somali community, he has lived in Bristol for two years. Since living here he has been involved in helping the Somali community. He is a volunteer at Amana and organises youth activities and teach Islamic culture, Maths and English. He used to teach English and Maths in Somalia and wanted to do the same work here. He became involved in the project because he is interested in the social needs of the community, especially the children and their future.

Saido Abdi

Saido has lived in Bristol for two years. She works in various local schools as an interpreter and does voluntary work in Amana. She is also studying an access course in nursing. Unfortunately, she had to leave the research team early to deal with family issues.

Lindsay Wall

Lindsay has lived in Bristol for nearly ten years. She is aware from other work experience that the needs of the Somali community are not always known to service providers. She felt that getting involved would help to highlight some of these needs so that hopefully the mental health services for young people could be improved or changed if needed. She has undertaken work with Transparency Research before with local Polish and Somali communities.

Latif Ismail

Before joining Transparency Research as Director, Latif consulted for various organisations including National Crime Squad, Serious Organise Crime Agency (SOCA) , Avon & Somerset Constabulary, East Bristol Youth Housing, Home Office, BBC Bristol, ITV West, Channel4/More4, Community @ Heart, Horn of Africa Forum and Brave Enterprise Agency. He had previously been a Service Development Officer and a Caseworker with Refugee Action, and his degree is in Development Studies from the University of East London. Latif is a qualified Business Adviser

Alex Hall

Prior to joining Transparency Research, Alex has previously worked for the Prince's Trust as Manager of Social Research and Evaluation, a Senior Policy Officer at Crisis and the Contracted Services Manager for the HIV Team at Kensington and Chelsea Social Services, before setting up Transparency Research in 2001. Alex has a degree in Philosophy from the University of Essex and a Masters in Race and Ethnic Relations from the University of London (Birkbeck). He takes particular interest in the development of database technology for research purposes.

2 Acknowledgements

In addition to the research team described above the following individuals were instrumental in completing this research:

Sue Topalian (Bristol CAMHS and Joint Commissioning Development Officer, Bristol PCT and Bristol City Council), Alison Cameron (Ethnic Minority Achievement Service Induction and Assessment Team Manager, Bristol City Council), Joanna Hicks (Senior Support Worker, Community Engagement Project, University of Central Lancashire), Mo Ismail (Headteacher, Amana Education Trust), Anne James (Principal Equalities Officer, Equalities and Community Cohesion Team, Bristol City Council), Faiza Khaliq (Community Development Worker, Avon and Wiltshire Mental Health Partnership), Lynn Maddern (Clinical Psychologist, North Bristol NHS Trust), Lorraine Millard (Young Peoples Health Development Worker, Community at Heart, Lawrence Hill and St Philips Youth Partnership), Marcel Osbourne (Community Development Worker, Barton Hill Settlement), Mark Patterson (Regional Race Equality Lead, Care Services Improvement Partnership (CSIP) South West), Miriam Morgan (Regional Race Equality Lead, CSIP South West (taking over from Mark Patterson)) Ruth Pickersgill (Equalities and Inclusion Manager, Children and Young peoples Services, Bristol City Council) and Claudette Radway (EMAS Manager, Bristol City Council), service providers interviewed and most of all members of Bristol's Somali community who came to the interviews and focus groups.

Contents

1 Research Team	1
2 Acknowledgements	2
3 Summary	5
4 Introduction	6
4.1 The Centre for Ethnicity and Health’s Model of community engagement.....	6
4.1.1 Background to the community engagement model.....	6
4.1.2 The key ingredients of the model.....	7
4.1.3 The community engagement team.....	9
4.1.4 Programme outcomes.....	9
4.2 The Somali Community in Bristol	10
4.3 The term ‘mental health’ and the Somali community.....	12
4.4 The Local Policy Context.....	14
4.5 The focus of this report.....	15
5 Methods	15
5.1 Who was recruited?	15
5.2 How were they recruited?	16
5.3 How the research team was trained and supported.....	16
5.4 What the research team did.....	16
5.5 How we selected our sample.....	17
5.6 Ethics	17
5.7 Role of steering group.....	18
5.8 How we accessed our communities.....	18
5.9 How information was gathered.	18
5.10 How we recorded interviews.....	18
5.11 How we analysed our questionnaires, interviews, focus groups.....	19
6 Findings	19
6.1 Core Data	19
6.2 Foreword.....	23
6.2.1 The Community Consultation	23
6.3 School and Education	23
6.3.1 Young People.....	23
6.3.2 Parents.....	24
6.4 Family Life.....	24
6.4.1 Young People.....	24
6.4.2 Parents.....	25
6.5 Thoughts, Feelings, Aspirations	26
6.5.1 Young People.....	26
6.5.2 Parents.....	27
6.6 Services	27
6.6.1 Young People.....	27
6.6.2 Parents.....	28
6.7 Views of Service Providers and Professionals.....	28
7 Discussion	30
8 Reflections	31
8.1 What worked well	31
8.2 What didn’t go so well.....	32
8.3 What would be done differently in the future?.....	32
8.4 Reflections on conducting the research.....	33
8.5 Communicating/engaging with the Somali community.....	35
8.6 ‘Saving Face’/Retaliation.....	35
8.7 Trust issues/ A fear of authority.....	36
8.8 General points about the focus groups.....	36
9 Recommendations	37
9.1 In relation to more appropriate and responsive services.....	37
9.2 In relation to community engagement	38
9.3 In relation to better information.....	38
10 Appendices	40
10.1 Steering Group Membership and Terms of Reference.....	40

10.1.1 Membership.....	40
10.1.2 Terms of Reference	40
10.2 Notes on Somali Culture.....	42
11 References.....	43

Tables

Table 1 Age of Respondents.....	19
Table 2 Gender of Respondents.....	19
Table 3 Self-reported Ethnic Origin of Respondents.....	20
Table 4 Born in UK and Length of Residence	20
Table 5 Citizenship Status.....	20
Table 6 Language Ability	20
Table 7 Religious Beliefs.....	21
Table 8 Sexual Orientation.....	21
Table 9 Presence of Disabilities.....	21
Table 10 Place of Residence.....	22
Table 11 Household Arrangements.....	22
Table 12 Is the family together?	22
Table 13 Country of Residence before coming to the UK	22

3 Summary

This community engagement research project is one of 80 similar projects undertaken across England from 2005-8. This particular research was conducted with reference to the Department of Health's (DH) Delivering Race Equality in Mental Health Care action plan (DRE). This plan aims to achieve equality and tackle discrimination in mental health services for all people of Black and minority ethnic status.

Previous research, anecdotal evidence, events in Somalia and subsequent migrations have all highlighted that mental health is a much misunderstood and under-researched area with respect to the Somali community. The lack of knowledge means that mental health problems are likely to be under-diagnosed and under-treated. This report attempts to address some of these shortfalls with respect to the Somali community in Bristol, which has in recent years been a rapidly growing population.

The research was undertaken by a Somali community research team working with a research consultancy and guided by a steering group of professionals and the University of Central Lancashire. The research took a year to complete and included a community consultation, interviews and focus groups with young Somali people in Bristol and their parents and interviews and focus groups with professionals in the area.

The enquiry was mainly qualitative in nature using semi-structured interviews and focus groups. In total 17 young people and 12 parents participated in the research. The results were analysed thematically, focusing on young people's and parent's views of school and education, family life, thoughts, feelings and aspirations and the services available. Over a dozen professionals working with the Somali community were also interviewed and everyone on the steering group was also involved in the delivery of services.

The research finds that the Somali community in Bristol has increased significantly in the last seven years as a result of both people fleeing continuing instability in Somalia and migration from within the UK and Europe. The community faces a number of issues including language barriers, legal (immigration) problems, housing and financial problems as well as cultural barriers. Additional problems include family separation and bereavement, and traumatisation.

However, this project highlighted that mental health itself is a difficult concept to research. It was found that members of the Somali community regard mental health as "madness", or psychosis, as untreatable, and as taboo.

The young people and parents who contributed to this research identified a number of issues relevant to mental health, including problems within schools, issues within the family and understanding of services. Particular emphasis was on language barriers, which can exist equally between pupil and school, between school and parent and between parent and child.

Knowledge of services and of how these were accessed was low, whereas need was thought to be high.

The research provides evidence for a number of recommendations which focus on more appropriate and responsive services, better community engagement and better information. This includes work both within the Somali community and the professionals working with them. Language needs have proven to be central to many of the barriers found, and this needs urgent resourcing. Additional recommendations include increasing the role of the Ethnic Minority Achievement Service (EMAS), awareness of contextual issues around mental health (housing, debt, etc.), and additions to citizenship courses.

4 Introduction

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

4.1.1 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 and Aimhigher.

4.1.2 The key ingredients of the model

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 community¹, 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.

The second key ingredient is the research task that the community undertakes. According to the Centre for Ethnicity and Health model, this must 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 and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be the first time that these individuals have undertaken a research project.

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 researchers². 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 and the researchers throughout the project. The University also provides a package of training, typically in the form of a series of accredited workshops.

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.

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 project³.

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

4.1.3 The community engagement team

The community engagement team comprises of senior support workers, support workers, teaching and learning staff, administration team and a communications officer. They work across a range of community engagement areas of specialisation, within a tight regional framework.

National Programme Directors			
Northern Team	Midlands Team	Southern Team	Senior Programme Advisors
Senior Support Worker		Senior Support Worker	
Support Workers	Support Workers	Support Workers	Drug Interventions Programme
			Citizen Shaped Policing
Teaching And Learning Team			
Administration Team			
Communications Officer			

4.1.4 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.

4.2 The Somali Community in Bristol

The Somali community was present in Bristol since at least the second half of the nineteenth century. Most of these were sailors and they settled mainly in harbour towns like Bristol, but were more prominent in Cardiff in particular.⁴

⁴ Indeed, the BBC notes that there is a Somali proverb referring to “Cardiff, my home”. Cardiff was also the scene of the first British Somali Society, set up in 1930. See http://www.bbc.co.uk/legacies/immig_emig/wales/w_se/article_2.shtml and Khoser 2003

At the end of the second world war, many Somalis resident in these harbour towns applied for their families to join them. However, the onset of instability in Somalia itself from the 1980s meant that the majority of Somalis entering the UK came as refugees.

Civil war had been brewing in Somalia since the 1970s, and started in earnest in 1988. In 1991 the dictator Siad Barre was overthrown. Since that time, despite temporary periods of calm, Somalia has had no effective government. Somaliland in the North declared independence in 1991 and remains a *de facto* independent state although unrecognised by foreign governments. The late 1990s and early 2000s saw various declarations of independence for various areas of Somalia, and various attempts at government, including the Somali National Movement and the Islamic Courts Union. With the exception of the reasonably calm Somaliland in the North, Somalia has remained tumultuous, suffering war, failed interventions by the United Nations and United States, and recently invasion from Ethiopia backed by the United States.

These events in Somalia itself over nearly 20 years has meant that Somalis have fled Somalia *en masse*. Some of these refugees arrived in the UK and tended to settle in urban areas. This coincided with most of the industrialised world restricting asylum procedures, and determining new immigration status including temporary protection or temporary leave to remain. Some of the effects of changes in legislation across Europe has meant that some Somalis arrive illegally and indirectly, and such that “the Somali increasingly find themselves in a precarious situation in host countries” (Koser 2003: 46). This situation alone has serious implications for mental health:

Living illegally, or with a precarious status, obviously does not make integration easy. Somali in exile have serious adjustment problems, and suicide rates are rising, although traditional taboos surrounding suicide make its rates amongst the Somali impossible to enumerate. Diaspora leaders have spoken out in particular against widespread racism against black people and prejudice against Muslims, into both of which categories Somali fall. (Koser 2003: 46)

While this places the situation of Somalis in Europe and Britain in some context, the situation in Bristol is particularly unclear. Even estimating the size of the community in 2008 is based more on anecdote than evidence. The 2001 census recorded just over 2,300 Black Africans living in the Bristol area. Possibly due to language difficulties, Somalis seeing themselves as Muslim rather than African, or under enumeration, this picture may not have been accurate in 2001. There is, however, consensus that the 2000s have seen a substantial upsurge of Somalis moving into the area. Research conducted in 2006 by Transparency Research found estimates of up to 17,000 Somalis in Bristol (Prosser et al 2006: 9), further estimates have gone as high as 20,000 (White 2008: 7). Regardless of what the true figures might be, it is clear that the Somali community in Bristol is considerably bigger than in 2001, and may constitute one of the larger minority groups in Bristol.

The reasons for this increase are manifold. Continued war and instability in Somalia itself will account for asylum seekers and some illegal immigrants. Secondary migrations by Somalis with settled immigration status in other

European Union countries means that they are able to exercise their treaty rights by migrating freely to another EU country, and there is some evidence that Somalis are taking this option, drawn by rumours of employment opportunities and the sizeable community already present (White 2008: .7). In addition, family reunion will also account for some of the increase. People granted refugee status once they have the resources will often seek to regroup their families, and bring additional family members from Somalia or countries where they have fled.

The subject of this research is the mental health of Somali young people in Bristol. This is a concern for a number of reasons. Firstly, it is self-evident that the experience of fleeing one's country will be traumatic. Often this will involve violent and distressing situations. The Somali route for illegal migrants and asylum seekers to the UK may also involve smugglers, and movement between differing countries. Koser et al (2003: 48) reports that there may have been (at the time) up to 3,000 Somali asylum seekers in Russia waiting to be smuggled on to Western Europe. This itself is continued disorientation and involvement, either willing or unwilling, with criminals. Continued reports of violence in Somalia will also have a disturbing effect, especially where family members may remain or be involved. The lack of a secure immigration status, and the threat of deportation for some, including that of family members will increase stress. Given the nature of war, it is also the case that many Somali families are headed by single women. Somalis retain close contacts with friends and relatives in Somali and collectively remit huge amounts of money to Somalia. These obligations can provide additional financial pressure on Somalis.

Notwithstanding these pressures, there are situations which are specific to life in the UK. Discrimination and prejudice have been noted above. Housing conditions are often cramped as families try to accommodate their extended members. Language barriers create additional problems and as majority Muslims, some find it difficult or undesirable to adjust to secular or Christian societies. Unemployment is high amongst Somalis (Koser 2003: 50) and there is dependence on state benefits. The use of khat is also habitual amongst some members of the Somali community which has been linked to wider social and individual problems (Ismail and Home 2005).

Young people may have experienced first hand some or all of the situations described above. Specific to younger people there has been seen a lack of appropriate role models and some involvement in crime. Furthermore, there is, within the Somali community a general reluctance to talk about "mental health".

4.3 The term 'mental health' and the Somali community

There is no direct Somali translation for the term mental health. The researchers did spend some time deciding on a term that would not alienate the community but as far as the group are aware there is not an agreed term that is used in this country.

A lot of people only agreed to be a part of the research as the researchers talked to the parents about how some Somali young people were under achieving at school and the problems associated with khat use and selling it. When the service provider who offered counselling sessions needed a parent's consent they would offer counselling as part of a learning package. The researchers explained that some of the problems that the young people were experiencing were due to a lack of communication and that the project, because it was looking at their needs, would help with their communication. It could also help with any misunderstandings and because the parents want to understand their children better and want to know a 'better way' they agreed to take part. The parents also want to communicate better with the schools and service providers.

Mental health is a taboo in the Somali community. One of the young people interviewed said that his father was dead rather than admit that he was in Somalia but had mental health issues. One Somali researcher said that in the Somali community *"someone who is mad is not a part of the society. They don't want anyone to know so they will reject all your ideas. Nobody seems to be talking about it in the community. They don't seem to be seeking help and will keep it indoors."* One researcher said that they had not seen many people with unmet needs.

Somali people may ask others to read the Koran to them to get rid of 'demons' but they wouldn't go to the Iman.

Even the service users did not readily admit that they were service users and it was difficult sometimes to know whether they were talking about themselves or someone they knew.

The Somali researchers said that people feel that they should conceal any mental health issues or ignore them. They believe that part of the reason why the parents didn't answer the question about services is because they were ashamed.

The researchers believed that the young people seemed more willing to talk about mental health issues more than the parents. After saying this many of the young people would not admit that they were talking about themselves.

The Somali researchers said that people would not go to the hospital because they are afraid.

One researcher said that there was a difference between mental health and confusion or misunderstanding. People do not understand what depression is but they will go to the GP with the symptoms. However, when the GP asks do you have any 'life problems' they will say no. The researcher believed that this happens because people don't make the connection between people's mental and physical health. The counsellor also believed this to be the case.

The Somali researchers believed that there was a need to increase awareness and understanding of mental health issues in the Somali community. At least one of the service providers believed this too. Said that there was a need to

explore the issues with the community and challenge some of the negative perceptions associated with mental health. It has not been done before because it's all new and it isn't something people talk about in their everyday life.

In Somalia people who have mental issues are not treated the same way as in UK. People have quite severe symptoms before anything is done and usually this would mean being locked up.

4.4 The Local Policy Context

Bristol's Child and Adolescent Mental Health Service's current strategy includes a commitment to improving its service to children and young people from black and minority ethnic groups. Actions have included the introduction of ethnicity monitoring and training in cultural competence. A team of six Mental Health Community Development Workers (CDW) for BME communities has recently been formed. The CDW team has four key roles: Access facilitator, Capacity Builder, Service Developer, Change Agent. This research will inform their work in relation to the Somali community and two of the CDW's have attended this project's steering group meetings since their appointment in early 2008..

National policies are impacting negatively on funding available for specific projects in areas with large BME communities. Nationally, the Neighbourhood Renewal Fund has been replaced by the Working Neighbourhoods Fund. National Criteria have been tightened, and Bristol is no longer eligible. This means that the current £6.1 m NR funding for 2007-8 will be reduced to £0 by 2010-11. There is some transitional funding in 2008-10, but many small projects are likely to be adversely affected by the end of this funding.

National policies on BME communities have moved from a multi-cultural approach to 'Community Cohesion' – working towards a society in which there is a common vision and a sense of belonging by all communities. It is considered that focussing on diversity and difference has the potential to divide communities, and the emphasis is now on promoting common bonds between communities. There is a move away from funding single issue groups towards funding projects that promote integration. There will be some funding to local councils over the next 3 years to promote this agenda.

Bristol City Council's Community Cohesion Strategy has four priorities:

1. *Integration.* Working to integrate new communities with existing communities by working with both to build relationships, promote commonalities and respect differences.
2. *Understanding and responding to changing populations* and developing cross-community and civic engagement.
3. *Tension reduction*, with a focus on anticipating, monitoring and responding to neighbourhoods at risk.
4. *Workforce capacity.* Developing the council's workforce to be culturally competent and reflective of Bristol's diverse communities.

CAMHS commissioners and stakeholders are in the process of devising an Emotional Health and Well-being Strategy for children for 2009 to 2014, and this project will contribute to informing that strategy.

4.5 The focus of this report

The research reported here was conducted with reference to the DH's Delivering Race Equality in Mental Health Care action plan (DRE). This plan aims to achieve equality and tackle discrimination in mental health services for all people of Black and minority ethnic status. The plan is based on three "building blocks" which include more appropriate services, increased community engagement, and better quality of information. On this basis, NIMHE was tasked in the DRE with improving services for specific populations, including refugees and asylum seekers. The action plan notes:

As well as experiencing the issues associated with the BME groups to which they belong, refugees have often been exposed to severe physical and psychological trauma as a result of war, imprisonment, torture or oppression. In their new host country they can then experience social isolation, homelessness, language difficulties, hostility and racism, all of which are strong predictors of poor mental health. DH 2005: 51

As part of the improvement of services, NIMHE funded the community engagement programme. This research sits broadly across the building blocks of the plan, while engaging the community it also suggests ways of improving services, and provides some information to service providers. It is in this context that this research was carried out. The broad aim was:

To explore the emotional and mental health needs of young Somali people (11-18 year olds) and their families and to identify any gaps in the community and statutory mental health services.

The key objectives were:

- To find out what the key emotional and mental health issues are facing young people and their families.
- To identify the main barriers for the Somali community in accessing mental health services.
- To identify if the services can be made more accessible, and if so how.
- To identify the types of emotional and mental health problems being presented.
- To identify whether there is a need for new services which are more culturally specific

5 Methods

5.1 Who was recruited?

The organisational approach for this piece of work differed in some significant ways from the model described above. Somali community groups in Bristol tend to be smaller and focus on some core needs, thus conducting a year-long

research project was going to be difficult. However, a partnership approach was adopted between the following organisations:

- Amana - a community based supplementary school providing additional support and lessons to young Somali people in Bristol
- Children and Adolescent Mental Health Services (CAMHS) who have responsibility for improving the mental health of Bristol's children and young people.
- Transparency Research Partners Ltd (TRPL) - a research and evaluation consultancy that has specialised in refugee and asylum issues and is led by former refugees.

The project was completed by four community researchers, all volunteers for Amana supplementary school, one co-ordinator engaged by TRPL, and two Directors of Transparency Research.

5.2 How were they recruited?

One of the Directors from TRPL is a former refugee Somali living in Bristol with a track record of community work and research in the area. The co-ordinator was engaged by TRPL on the basis of working with the Somali community for a number of years and ability to work in a diverse environment. The volunteers were recruited from Amana; gender and clan were considered when recruiting the researchers with two males and two females, one of each from the North and South of Somalia. The remaining Director provided technical support.

5.3 How the research team was trained and supported

- Fortnightly meetings with a support worker from UCLAN
- Attended five workshops (three on community research, two on mental health). All had the opportunity to study for Uclan qualifications. 3 took up this opportunity and have gained Certificates from the University.
- Regular meetings between the co-ordinator and community researchers
- Regular meetings with TRPL director. Met as a group and coordinator also met with director on a regular basis.
- Community researchers were also given additional training on focus groups, interview techniques and data analysis.
- Regular phone and email contact between the meetings.
- Attended steering group meetings

5.4 What the research team did

The following activities were arranged by the researchers:

- Organised a community consultation. Attendance included parents, the research team, members of the steering group and key people working in the Somali community. In total 25-30 people attended.

- Interviewed four young people who were using additional educational services (these are described as “service users” in the remainder of the report).
- Organised and held four focus groups, two with young people and two with parents. In total 12 parents and 13 young people attended.
- Interviewed professionals working in mental health services and special educational needs co-ordinators (SENCOS). In total ten people were interviewed.

One of the more difficult tasks for the community researchers was recruiting young people and their parents for the primary research. Despite the generally positive outcomes of the community consultation meeting, parents and young people were reluctant to take part, partly through circumstantial reasons such as transport and time, but also through reluctance to discuss the subject in hand.

5.5 How we selected our sample

Selecting those for interview and focus groups was difficult for the above reasons, and ultimately the sample was selected via ‘purposive sampling’: three of the service users were identified by a service provider and the rest were identified by the community researchers in the community.

Additional changes were made during the course of the research as issues developed. A focus group for girls as well as boys was held as some school staff and the research team had expressed concerns about the girls and felt that their concerns may be different. It was also agreed that having same sex focus groups would work better culturally - girls may feel more comfortable in a female only environment, and equally it was felt that boys may better express their views in a same gender group.

5.6 Ethics

UCLan requires all community engagement groups to undertake a rigorous ethical procedure. A proforma was completed and subsequent amendments and additions made to procedure for collecting data for this project. In particular, since this project was working directly with young people, it was especially important to ensure that research subjects were appropriately informed of the research being undertaken and protected from any potential harm. Key areas highlighted were as follows:

- All the researchers had a CRB check
- All the researchers have some experience of working with young people. All of them are volunteers at the supplementary school. One person works in a secondary school
- Ensuring that the info given was appropriate
- Consent of young people as well as parents was sought and documented
- Confidentiality was explained and assured to participants where possible (e.g. Focus groups, by their method, could not be completely confidential).

5.7 Role of steering group

The steering group provided a range of expertise and experience, provided contacts and ensured the project remained on focus.

The Steering Group is chaired by a representative of the Joint Commissioners of CAMHS, and the findings of the report will feed into the city's Children and Young Peoples Emotional Health and Wellbeing Strategy for 2009-2014. Representatives of Community Cohesion, Children and Young Peoples Services Equalities Section, CAMHS and the Community Development worker team have been included in the steering group to ensure that the recommendations of the report are considered in planning at operational and strategic levels.

The steering group is detailed in Appendix 10.1

5.8 How we accessed our communities

The researchers were well known within the Somali community and were all regarded as being helpful people. This was useful for recruiting participants. All the researchers were volunteers at a supplementary school where over 100 children attend every weekend.

The research began with a community consultation as prior experience suggests that the Somali community is best contacted primarily via verbal/spoken methods. This was to try and inform people about what we were doing and to encourage participation.

All the community researchers were Somali but they were born in different parts of Somalia and would have different social networks. This was important to ensure representation from the different areas. We also had two female and two male researchers in order to access both males and females. All of the community researchers were associated with Amana supplementary school and this helped in reaching particular individuals.

5.9 How information was gathered.

1. Semi structured interviews with the young service users were used on a one-to-one basis to ensure confidentiality. Community researchers interviewed the young people on a one to one basis.
2. Two focus groups with parents were held: One focus group with the parents of non-service users, the second with parents of service users.
3. Two focus groups with young people aged 12-16. One for boys, one for girls.
4. Quantitative data from interviewees was collected on forms from the all the above respondents.
5. Interviews with SENCOs and services providers.

5.10 How we recorded interviews

Nobody from the Somali community-including service providers wanted their voices to be recorded and thus notes were taken by hand, in English. Some of the service providers were recorded on tape.

5.11 How we analysed our questionnaires, interviews, focus groups

Notes from interviews and focus groups were taken by the community researchers and other members of the research team. Where the conversation was taped (only with some service providers), this was used to assist in note taking. Translation (where Somali was used) was conducted by the community researchers as they took their notes, and the use and meaning of specific words was discussed between the (Somali) community researchers and (English) co-ordinator to agree on the core meaning where this was difficult. Explaining the term “mental health” into Somali (which tends to use a word meaning “madness”) was the main issue which was settled early in the community consultation. The notes were collated and as most of the evidence collected was of a qualitative nature we used thematic analysis. Quantitative data was summarised in tables.

6 Findings

6.1 Core Data

Below is a summary of the quantitative data collected from forms used prior to interview or focus group. Please note:

- Eight of the parents did not complete forms at all. There was generally a lack of understanding about using the forms and distrust about completing them.
- Further confusion is in evidence in the description of ethnicity. The research team confirmed that all of the interviewees were Somali, and hence would traditionally be classified as “Black or Black British - African”, or “Black or Black British - Other - Somali”, however some obviously interpreted the question differently or misinterpreted it referring to themselves as mixed race.

Table 1 Age of Respondents

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
Up to 15 years	13	76%	40-49 years	3	25%
16-18 years	3	18%	50 years and over	1	8%
No answer	1	6%	No answer	8	67%
Total	17		Total	12	

Table 2 Gender of Respondents

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
Male	10	59%	Male	6	50%
Female	7	41%	Female	6	50%
Total	17		Total	12	

Table 3 Self-reported Ethnic Origin of Respondents

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
Black or Black British – African	14	82%	Black or Black British – African	3	25%
Black or Black British – Other – Somali	1	6%			
Mixed White and Black African	2	12%	Mixed White and Black British	1	8%
No answer	0		No answer	8	67%
Total	17		Total	12	

Table 4 Born in UK and Length of Residence

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
Yes	4	24%	Yes	0	
No	13	76%	No	4	33%
No answer	0		No answer	8	67%
- If no, how long in UK			- If no, how long in UK		
1-5 years	9	53%	1-5 years	2	17%
6-10 years	2	12%	6-10 years	1	8%
11 years or more	1	6%	11 years or more	1	8%
Total	17		Total	12	

Table 5 Citizenship Status

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
Refugee	8	47%	Refugee	1	8%
British	8	47%	British	1	8%
Other – Flemish	1	6%	Other – Dutch	2	17%
No answer			No answer	8	67%
Total	17		Total	12	

Table 6 Language Ability

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
Fluent Written English	13	76%	Fluent Written English		
Fluent Spoken English	2	12%	Fluent Spoken English		
Fluent Written Somali	8	47%	Fluent Written Somali	4	33%
Fluent Spoken Somali	14	82%	Fluent Spoken Somali	4	33%
Fluent Written Flemish	1	6%			
Fluent Spoken Flemish	1	6%			
No answer			No answer	8	67%
Total	17		Total	12	

Note: People were competent in more than one language, hence total > 100%

Table 7 Religious Beliefs

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
Islam	15	88%	Islam	3	25%
Buddhism	1	6%			
No answer	1	6%	No answer	9	75%
Total	17		Total	12	

Table 8 Sexual Orientation

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
Heterosexual	17	100%	Heterosexual	3	25%
No answer			No answer	9	75%
Total	17		Total	12	

Table 9 Presence of Disabilities

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
Yes			Yes	1	8%
No	14	82%	No	3	25%
No answer	3	18%	No answer	8	67%
Total	17		Total	12	

Table 10 Place of Residence

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
St Pauls	9	53%	St Pauls	3	25%
Easton	4	24%			
Whitehall	1	6%			
Fishponds	2	12%			
Redcliffe	1	6%			
No answer			No answer	9	75%
Total	17		Total	12	

Table 11 Household Arrangements

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
Live with nuclear family	16	94%	Live with nuclear family	3	25%
Live with extended family	1	6%			
No answer			No answer	9	75%
Total	17		Total	12	

Table 12 Is the family together?

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
Yes	13	76%	Yes	2	17%
No	4	24%	No		
No answer			No answer	10	83%
Total	17		Total	12	

Table 13 Country of Residence before coming to the UK

Young People			Parents		
	<i>n</i>	%		<i>n</i>	%
Somalia	5	29%	Somalia	1	8%
Somaliland	5	29%			
Ethiopia	2	12%			
Belgium	1	6%			
Holland			Netherlands	2	17%
Born in UK	3	18%			
No answer	1	6%	No answer	9	75%
Total	17		Total	12	

Source for all tables: Fieldwork 2007-8

6.2 Foreword

It is important to note that conducting research on mental health issues amongst Somalis is problematic in itself. Firstly, there is no equivalent terminology in the Somali language to describe mental health, and this was the source of some considerable debate amongst the research team (Please see Section 4.3). Indeed, this also affects the description of symptoms:

Somalis do not 'hear voices': they 'talk to themselves'. So an interpreter or carer may tell the doctor that the patient does not hear voices, when in fact they do (Rai-Atkins 2002: 23).

Mental health is also considered taboo amongst many Somalis, and is associated with fear, shame, and stigma. It can often be attributed to spirits and is often felt to be a permanent affliction (Hitch 2006: 127, Rai-Atkins 2002: 23). Thus in the research discussed here, respondents would often talk around various issues, and it was quite common not to be able to distinguish when respondents were talking about their own perceptions and feelings, or those of others.

6.2.1 The Community Consultation

The research commenced with a community consultation event in July 2007 with 25-30 people attending including the research team, professionals working within education and mental health services and members of the Somali community. A presentation was given by the Regional DRE Race Equality Lead. The consultation operated firstly as an introduction of the research to the community and to draw out specific issues and challenges. One of these was the correct terminology to use when discussing mental health with the community. This was introduced by one of the research team and this terminology (“Maan”) was used during the research. This terminology generally got a favourable reception. The community felt there were the following additional issues:

- People were concerned that young Somali people would be stereotyped.
- The research could be the beginning of changes and hopefully will help parents to support their children.
- They felt that the mental health of young people could not be separated from their education

On the whole the community supported the research and thought it would benefit the community.

6.3 School and Education

6.3.1 Young People

The young people interviewed mentioned a number of concerns at school. Relationships with other pupils could be difficult and three of the four interviewed mentioned bullying on the basis of being a “refugee” and poor English skills. Bullying was stated to come from African-Caribbean pupils.

Bullying was mentioned in the boys focus group also, with incidents as unpleasant as people being spat on, and neighbours throwing eggs.

Relationships with teaching staff could also be difficult. Problems cited were around communication and they often found it difficult to communicate with staff. One additional problem was suspicion of carrying a weapon: the pupil was asked to be searched in order to look for a weapon.

The focus group with boys also talked about the problems of starting a new school in a new country. They had to get used to the new rules and there were various difficulties including bullying, lacking confidence and coping with the school system. In this respect Amana was helpful as they worked within the same language.

6.3.2 Parents

Focus groups with parents also revealed a number of problems with schools. Communication was difficult in a number of contexts, between the parents and their children, the parents and the schools and between their children and school staff. In the first instance the young person would often have better command of English than their parents which led to a communication barrier between the young person and their parent. Secondly, there was a lack of contact between schools and parents, most often due to language barriers, and a lack of Somali teachers who could facilitate such communication. Thirdly, communication problems between pupils and teachers were also problematic; for example, some schools resolved fights and disputes between pupils by asking both to write a report about the fight after the event. Given that one child has better command of English than another means that one is disadvantaged; in at least one case the Somali pupil who could not write in English was excluded for being unable to write the report. This particular example was cited by both pupils and parents and would appear to be a fairly common issue.

Problems with schools and education cited by parents focussed on communication barriers. As such, there was some worry about their child's attainment at school including inadequate support from teachers, the parents own inability to support at school (due to language barriers again), children being put in classes with different age groups, as well as problems which prevented education such as fighting and bullying. One parent's daughter noted that she had had no education prior to coming to the UK and was seen as inferior and bullied on the basis of her ability.

Remaining concerns about school life and education for their children were also familiar to all parents including issues such as class sizes and children going to school late.

6.4 Family Life

6.4.1 Young People

According to the young people interviewed, relationships with parents were very mixed affairs. Communication was said to be difficult; some of this was attributed to culture clash with parents adhering to values in Somalia but children adapting to life in the UK, with risk of “loss of identity”. Associating with the “wrong crowd” was mentioned as a concern and others seeking to make money quickly and getting involved in crime and drugs. This was obviously some cause for concern as parents (see below) also expressed similar concerns.

The focus group with girls also mentioned problems of young people selling drugs for quick money and they felt there was pressure on boys to do this. However, this behaviour had a number of reasons: not only money but for esteem amongst peer groups or as an escape from family problems. It was noted that the parents were brought up in a different world.

However, despite these issues, both boys and girls stated that if they had a problem they would go to their family members. Boys mentioned their mum more often although girls said that they would also talk to sisters and to their friends. Fathers were not mentioned as much - the boys said that they were busy. All the girls said they communicate well with their parents. For many of their immediate role models were family members.

The focus group with boys also spoke about family separation, with parents and children arriving in the UK at different times and the pain that separation and problems that subsequent reunion brought. There were concerns about family members remaining in Somalia and they didn't know if their parents and other family members - at various stages of the separation - were alive or had been killed.

6.4.2 Parents

Life at home, and relationships with their children also raised a number of difficulties with parents. Some problems will be familiar to many parents bringing up children but with additional issues. Parents expressed concerns about the appearance of their children and their dress sense. This was tied in with additional concerns about behaviour and for one parent at least, the suggestion that the young person was losing contact with his parents culture and values: *“I am worrying about the way he wear his clothes, the way he walks and the way he speaking. I am afraid he is loosing his identity.”* (Parent of non-service user). A lack of connection was a concern with another parent who was trying to teach the principles of Islam, however conversations often resolved themselves to conflict. In addition to this were fears about becoming involved with drugs, smoking or khat.

English language skills were a recurring theme and inhibited the ability of parents to help and understand their children. One parent noted that the level of learning between the child and the parent was the same, that the English language used by the young person was not understood by the parent, and that they were unable to help with school work. Indeed in one case it had led to conflict. A parent said: *“He always speaks English and ridicules me if I try and speak English saying that I'll never learn English.”* Another said that she

was not able to understand a GP's advice and was unable to provide the right care for the child.

Parents noted that many households were single parent households, headed mostly by the mother. Many parents thus indicated a lack of time to devote attention to their children, and this was exacerbated by financial problems. Their children would want things that they simply could not afford but that they had seen other children have. Parents had commitments to provide financial assistance to their family remaining overseas, and conditions were overcrowded at home which made paying attention harder. Some bemoaned Somali families saying that the parents don't take enough interest in their children and do not take them to parks or swimming.

To some extent the external society outside of the home was perceived as dangerous and there were many influences on their children's behaviour that were considered undesirable. Notwithstanding problems at school, additional issues included lack of facilities, hanging around with what would loosely be called "the wrong crowd" and implications of criminal behaviour. Another noted that their child "didn't feel safe outside" and would come back home early - which was contrasted with the conditions in Somalia.

There was little mentioned by sources of help. Parents noted that there were few community organisations in the city that could offer support, and in any case, there were clan differences within the Somali community that made such organisations difficult to run or to be united.

Parents expressed considerable concern about their children's well being. Children displayed various behavioural challenges including appearing nervous, being aggressive, refusing to communicate, and arguing. In addition, parents did not often feel to be in a position to help: *"I know he has problems with his homework, but I haven't got the time or ability to help"*.

6.5 Thoughts, Feelings, Aspirations

6.5.1 Young People

The young people interviewed mentioned a number of concerns and worries, mostly about their future. One wanted to make his family proud and another noted that they knew they were "different", and this itself caused concern about the future. Some of these feelings seemed to stem directly from experiences in the UK, in particular bullying. Two said that they were sad, not knowing why people were unpleasant to them when they themselves had not done anything. The focus group with boys indicated a similar set of concerns including bullying, but also mentioning English skills but moreover concerns for the future including getting a good job. The focus group with girls found concerns with school, as well as crime.

Anger was also mentioned in the interviews with boys, again as a response to bullying and sometimes this led to physical confrontation. One boy said that on being bullied he subsequently found his tormentor and "sorted him out". The respondents felt that anger and fighting was a response to intimidation

and bullying. Other respondents also indicated a range of emotions including sadness, being upset, worried about the future, being ashamed, depressed or not valued.

However, those interviewed also employed a number of coping strategies. One person said that fighting (again as a response to bullying) was how feelings were dealt with: “[I will] not let the other people do what they want with me”. Others said they would try and keep cool (three people), try and forget about it, such as playing a computer game, move away from the situation or be with friends. When asked who they would talk to about their worries, all mentioned family members (mother, uncle, father) and friends and teachers. Focus groups revealed further strategies including sleeping, playing games, crying or watching TV. Boys would all talk to their mothers, the girls mentioned a variety of family members including sisters and fathers as well as friends.

Despite their worries for the future, most interviewees had high aspirations. Two wanted to be football players, two wanted to be doctors, one an engineer. One who had dyslexia wanted to read and write more. High aspirations were also found in the two focus groups. Two boys wanted to work with computers, the remainder wanted to be a teacher, doctor, pilot, and businessman. Girls wanted to be a lawyer, a nurse, a doctor, a radiographer, a surgeon and a businesswoman. One wanted to be “successful with a proper job” and another wanted to learn the Koran.

Despite the pressures and circumstances noted above, most it seemed were aiming high and had developed strategies for coping with unpleasant situations.

6.5.2 Parents

Parents were not asked about their child’s future aspirations. They were asked, however, about communication between them and their children and their children’s strategies for coping with difficult situations. However, responses were limited, saying that their child was able to talk about things, but not always could the right remedy be found. Communication was difficult from the parent’s point of view (see above), but various solutions and methods of coping were also mentioned, including paying an elder daughter to teach her siblings, sitting down and discussing with the child various issues, and using religion and culture to persuade the young person to reflect on their actions.

6.6 Services

6.6.1 Young People

All respondents had a very limited view of the services that were available to them, although it should be noted that an “appropriate” level of knowledge of statutory and voluntary services for this age group has not been defined. The boys interviewed had more knowledge however, responses were vague and in some cases generic. The mentioned doctors, ‘specialists’, a ‘learning-hospital school’ and school staff and mentors. These people helped them with a variety

of issues including educational support, ideas on how to move forward, advocacy (the “*learning mentor used to talk to me and would speak to all the other people involved in a situation*”), and help them keep cool.

Services provided were, however, viewed as mixed. One said the support was always useful to both him and his mother (seeing a ‘specialist’ - thought to be an educational psychologist), another that the mentor “*Helped for a while, then started to act weird*”, following exclusion from school. Improvements suggested greater language support for parents so that they could understand the situation better, continuity of service, and having more time.

None of the focus groups were able to name any services available.

Views of mental health were also mixed, and variable. One interviewee stated he didn’t know what the words meant but the ‘specialist’ tried to help him understand and it helps both him and his mother. Another stated mental health is “*a brain illness: if you think a lot you will be stressful [sic] and it makes your brain shut down.*” Focus groups also gave mixed definitions. The girls said it was about not being in control, not acting normal, needing help, and needing to take pills. They also noted that people with problems should not be judged, nor assumed to be bad, and that they should be worked with. The boys focus group referred to disabled and crazy people.

6.6.2 Parents

Parents of boys interviewed were vague in their understanding of services, apart from one knowing that the GP referred them onto further services. However, they did also note that they tried to understand how to best work with services, and to attend appointments (although one noted that there was not enough time) and provide additional support for their children. Culture and religion played a role, one would speak about Islam, another parent would teach prayer. Parents of children not involved with services mentioned even less, and cited language barriers.

None of the parents responded to the question of improvements to services.

6.7 Views of Service Providers and Professionals

Ten professionals providing services were interviewed across Bristol regarding their involvement with other services and the Somali community, and a meeting with CAMHS workers was held in January 2008. Services provided included educational assistance, family and parenting support, various elements of the local educational authority and community organisations.

Individuals were asked about particular barriers that the Somali community faced in accessing services. Apart from one service that was set up as multi-lingual, most mentioned language barriers. This could include very specific issues such as translation of scientific terminology between English and Somali as well as problems such as understanding between doctors and

patients. Language barriers themselves could cause problems in terms of mental health. One professional elaborated:

I think the language barrier is a potential cause of mental health problems because it's extra stress for the students who come to the school or are new arrivals who haven't experienced school before and they have got to learn to communicate with other students and learn the school curriculum. They can't do this if they can't speak English very well. The longer it takes them to learn English it just keeps that stress level going. So I would be very keen to have services available to help their English.

Another highlighted the situations within a school:

I think it is very difficult when they come to this country and they do not speak any English and the culture is different. I think it's very difficult for the children to integrate quickly into mainstream English schools especially at secondary school level. Where they may have never been to school at all before ... They suddenly find themselves thrown in to a class of year seven or eight. ... If we can have more English classes as a foreign language available to the student they can more quickly learn English and be able to access school.

Cultural issues were mentioned less, although there was certainly mention of particular caution regarding mental health services: parents were wary of counselling services as they felt this may lead to labelling as mad or crazy. This was overcome by 'packaging' the counselling into combined services providing assistance with learning, although there was still reticence. Other problems also included lack of legal status, lack of transport and general poverty.

While many professionals did not have regular and established links with mental health services, there were concerns on this issue, particularly with Somali children:

I don't really have any knowledge of what services of young children have but I do believe a large number of the children [who] come to this school may have mental health problems. Maybe this the reason why they come here and back and it often causes problems for them in class if they have got behaviour difficult sometimes. Pupils can get angry in lessons and are very vulnerable to other students.

Traumatisation was cited by professionals as cause for concern. This was related to family disruption including death of family members and long periods of separation while fleeing Somalia. In the first instance the trauma had not been treated and there was anxiety in some parents over revisiting the cause. It was hard to distinguish between the young person's and the parents symptoms, and this was described by one as "inter-generational trauma". In addition, parents often had fear of authority figures and fears that their children will be taken away. These factors in total both made it harder to access mental health services, while also highlighting the need for these services. CAMHS workers also indicated that there was evidence of this need being identified more in primary schools which was considered worrying.

Suggestions for improvement of mental health services included employing more Somali speakers, and proper education within the community about the services and how they work. Link workers between the community and the statutory services were mentioned as a possible solution, and could also advise

both professionals and community members. Effective referral systems were mentioned as being able to properly direct people. Flexibility and being open to change and experiment amongst organisations and bodies dealing with the Somali community was highlighted, whereas equally another interviewee highlighted the need for members of the Somali community itself to realize its potential to help bridge gaps and start to work in key services.

7 Discussion

This research can draw a number of conclusions based on the evidence here.

Firstly, there has been a rapid rise in the number of Somalis living in Bristol in the last seven years, with significant impact on the make up of the city's population. Somali experiences include numerous factors which often lead to poor mental health. These are detailed comprehensively above, but can be briefly summarised as traumatisation in the process of fleeing a war-torn country, insecure immigration status, language barriers, discrimination, cultural barriers, housing, family, and financial problems and different expectations. This means there is significant unmet need for mental health services amongst this community.

Secondly, it is very difficult to conduct research on mental health within the Somali community. This research demonstrates that you can employ every feasible method to engage the community on this subject including taking a year to conduct the research, employing well-respected members of the Somali community to conduct the fieldwork, make time and space available for interviews and focus groups, explain the nature of the research both verbally and in writing to potential participants, develop a new and particular terminology to assist in the research and still respondents are very reluctant to discuss mental health. This is largely due to stigmatisation of "mental health" amongst the Somali community and its association simply as "madness" rather than as a treatable condition. This is exacerbated by there being no accepted direct translation of appropriate terminology within the Somali language.

With specific regard to the results of the research there are a number of broad conclusions. For Somali children, school life can be a traumatic time. Bullying would appear to be problematic but moreover language difficulties make it particularly hard. Being new, many did not have an understanding of what was appropriate within schools and there were cases of misunderstanding between pupils and teachers.

Family life also presented a number of issues. In some respects, children were more positive about their relationships with parents than vice-versa. Parents were concerned about many things including their child's academic attainment, attachment to cultural identity and religion, and they also expressed fears about crime and other problems. Alternatively, the young people reported that they saw their parents and other family members as role models and generally felt that they could talk to them.

Equally encouraging were the high aspirations of the young people in the research. While they cited specific situational problems and negative emotions, they all generally had aspirations to professional and productive employment or self-employment. Furthermore, they were able to collectively employ a number of coping strategies for negative feelings and situations.

Knowledge of services amongst the Somali young people and parents interviewed was clearly less than adequate, especially given the nature and potential nature of mental health issues within the community. Service providers also indicated that provision for Somalis - while good in some circumstances - was difficult and there were many barriers between the service and the potential service user.

Language was a consistent feature throughout the research and caused a barrier in many different ways: it could cause a barrier between parent and child, between the young person and the school, between the parent and the school, and between both young people and parents and statutory and voluntary services. It was further highlighted that lack of English language skills isolated people and added to stress and potential mental health issues.

8 Reflections

The following paragraphs are based on an informal discussion with the community researchers and the work they produced for their certificate.

8.1 What worked well

All the researchers attended the workshops and have gained many skills. In particular:

- The workshops in Exeter. People enjoyed meeting other people and felt that they were a good start to the project.
- Group meetings
- The interviews were well organised and structured and well presented
- Developed new skills- communication skills, listening skills, presenting information. All of them felt that their confidence and self-esteem had increased.
- Although none of the Somali researchers had read the information they were given at the workshops they felt that they would be useful in future work.
- Made intensive use of bi-lingual dictionaries to ensure that translations were accurate.
- Learnt about the real emotional needs of the young Somali people and their educational achievement
- Were paid for their skills. This was quite important as they did a lot of voluntary work for their community.
- Learnt that a person's mental state and their behaviour could be connected.
- A good opportunity to learn more about mental health issues.
- Doing the interviews gave the researchers a better understanding of their feelings and perceptions.

- One researcher has bought some books on mental health so that they can learn more. All of them said that they now have more of an interest in mental health issues.

8.2 What didn't go so well

- Workshops: It was very detailed at the workshops and sometimes it was difficult to concentrate. They were also long days.
- Trying to persuade people to be interviewed. People were unsure of the aims and objectives of the project and the term mental health. People could only refer to their experiences in Somalia where people with a mental health issue are treated very differently to people here. Also, many people had not seen anything like this before and were unclear what it was about. Some people when asked just said "*I don't know what you are talking about.*"

The researchers had to spend a lot of time ringing and visiting people before they would agree. Other questions people asked were: '*Why are you discussing mental health?*' '*Whose concern is it?*' '*Are Somali people over represented in the mental health system?*' '*What is the aim of the project?*' '*Why this particular time?*' '*What are the positives and negatives of the project?*' '*What are the outcomes?*' '*How will it benefit?*'

- It was also difficult to persuade people because of a lack of time. Transport was also an issue for people. The interviews with the young people were shorter than planned because of difficulties around transport.
- Many of the parents refused to fill core data forms either because they were afraid to do so or because they did not understand them. A lot of the young people also had difficulties completing the forms and needed quite a lot of support to do so, although most of them had been here for more than four years.
- The Somali community is an oral society and at the beginning of the project the researchers struggled with the concept of the research until the practical work began. Up to then the researchers had only attended workshops and were asked to write things like the interview schedules and the ethics form.
- People did not want to get involved because of the topic
- People were also afraid of 'opening up' which made the interviews more difficult. People, especially the children, seemed wary of saying anything bad about their families.
- A number of the respondents in this research were known to have had traumatic times at school and pressing and destructive events within the family. It is notable that none of these issues were presented in the discussions.

8.3 What would be done differently in the future?

- Improve time management. Arriving on time or remembering meetings was an issue at the beginning of the project but everyone's time management improved. One of the researchers said that in Somalia the days were long and that time was never an issue and that it was difficult to change this attitude. It is also important to remember that people's lives can change quite quickly, especially in an unsettled community like the Somali community. Some of the researchers were trying to cope with quite stressful situations e.g. one person had received an unexpected phone call telling them that their brother had just arrived in the country from a refugee camp in Ethiopia. They were unable to attend a couple of meetings as they dealt with the family.
- The research design itself could be reconsidered. While the researchers took one year over the project, were from the Somali community and respected within it, and planned and executed the research well, it was still difficult to deal with the subject area for those interviewed. Future research could take a different approach, perhaps using case studies of individuals over a year to get a perspective on wider issues in the lives of young Somali people.
- As further discussed below, there are conceptual difficulties using definitions of mental health in the Somali community and that understood by professionals. This particular issue permeates the project from the beginning. For the Somali community, mental health refers to madness, or psychosis, the broader meaning held by the wider community and the research team, was simply not shared, despite the hard work put in on developing the concept at initial meetings and with parents and young people. Working on broader concepts may be more fruitful, perhaps examining the stresses of life in Bristol and emotional adjustment to it. Future research should consider development of a shared concept, perhaps starting with emotions such as being angry, frightened or happy and moving forward from there.

8.4 Reflections on conducting the research

All of the group members did the following activities:

- Chose a name for the project. Sahan (Explore) – Amana
- Helped to organise a community consultation
- Attended the workshops run by the university
- Helped to identify the aims and objectives of the project
- Collected relevant information
- Thematic analysis
- Wrote up interviews
- Completed the ethics forms for the university
- Considered health & safety issues
- Team work
- Interview techniques
- Helped to organise focus groups
- Persuaded people to get involved
- Gained a greater understanding of confidentiality issues

One of the researchers said that although community research was new to them they believed it was possible and quoted Napoleon Hill “*Whatever the mind can conceive and believe, it can achieve.*”

One Somali researcher said that it was difficult for them sometimes because they were brought up in Dubai and they could not always join in with the conversations when people were talking about Somalia. Also, although this person could speak Somali it was not their first language so sometimes the co-ordinator had to intervene if they felt that they were being teased because of difference in language or culture. Although there were four Somali researchers there were cultural differences between them.

Although there were originally two female researchers in the team, one of them had to leave due to personal circumstances. However, the remaining female was asked by the coordinator to talk about her experiences on the project as she didn't complete the written reflections exercise. She said the following:

- That she had learnt to be more determined and not to give up. At the beginning she did not want to do the research because it was all new and she was worried about doing it.
- Her confidence had grown considerably and that she felt confident doing public speaking as well as talking to men.
- She learnt what it was like to work in a team and to think of others and to be polite to them and show kindness and concern. She had always been a lone worker before getting involved in this research.
- She learnt to manage her time better and to get to meetings on time
- Learnt the importance of listening which was quite an achievement as the Somali community is a talking society.
- Learnt not to judge the book by the cover and to at least try something.
- She learnt that her opinion did matter. When there were two female researchers she felt more comfortable talking but when the other lady left she felt more apart although the men did ask her opinion. This was quite important because she said in traditional Somali culture the men and women do not usually discuss things together. She also said that before the research began the men and women were separate but now the atmosphere seems to have changed. She said that she felt more comfortable approaching men because she had learnt that it was possible for men and women to work together. She said that this was difficult at the beginning because the men were closed but it was easier now.
- As she was the youngest member of the group she learnt a lot from other people but also felt at times excluded because they treated her like the youngest.
- In summary she said “*I am a person who has more personal skills, I am more confident and someone who is determined and open-minded and I can communicate with different types of people*”, “*Now I have a sense of adventure and want to explore more*”, “*I want more adventures and want to know what are the hidden things behind the scenes*”.

8.5 Communicating/engaging with the Somali community

As a group we talked about how they had communicated with people and persuaded them to get involved. They did feel that the fact that they were known to the community or were associated with Amana was important but they also said the following:

Need to write things in a way that is appropriate for the community. Translated materials can be useful and can be used to advertise meetings and to give information about a service. One of the researchers felt that a leaflet was 'no good.' The coordinator said that in her work experiences leaflets had minimal effect and that 'word of mouth' seemed to work best when arranging a meeting.

However, as the Somali community is an oral society and people like to talk the best way to get information to people is in the oral form. Although the telephone is a good way to communicate people do not always absorb the words so they will forget a thing so the best way to is to visit people. They said that people tend to remember what you've said in a face to face interview. Some of the service providers did phone and visit people as well as send out letters.

Being personally introduced to someone helps to ease communication. One of the researchers was worried about contacting someone as the person who had given them the contact details had gone away and could not give them a personal introduction. They said that if they 'if they know you enough they will work with you' and that being with Amana helped.

A significant number of Somali people will not answer their mobile if they do not know the number.

To ensure that someone makes an appointment may need to call and then visit and then ring again to confirm that they are coming.

The Somali community tend to respect 'experts.'

8.6 'Saving Face'/Retaliation

'Saving Face' may happen when people say that nothing is happening with my children. They will say that nothing is wrong and this may be particularly true for single parents who may feel more reluctant to talk about their problems. This could be important when you consider that 60% of all Somali families are headed by single women. (Barnardos research)

Some of the young people interviewed said that they wouldn't start a fight but if someone started on them, they would fight back. Being seen as a 'strong' person who will not let people walk over them is quite important in the Somali community. Also, culturally getting back at someone who has done you wrong is seen as the norm. There are quite a few sayings in the Somali language

around this and some young people may experience peer pressure if they don't react.

8.7 Trust issues/ A fear of authority

Respondents were afraid that the information they gave would be misused. They did not want any trouble. Both the community researchers and a service provider said that this was an issue for people from the BME communities, especially if they were waiting to hear about their legal status or had newly arrived to the country. People were also worried that the information given would go to different people

People were also afraid that social services would take their children away if they talked about any problems they had. When the coordinator talked to the researchers about this they said that some Somali families had recently had their children taken in to care but they had not really understood what was happening. Social services apparently are aware that the Somali community are wary of their services and apparently want to talk on Somali radio about their service to try and allay some of the fears in the community.

A lack of trust in strangers and authority figures in general can be an issue and the researchers had to work hard to get people to agree to take part. All of the researchers are well respected within the community and they believe that a big part of the reason why people agreed to take part is because people knew them through Amana and because they were known to be religious people. The researchers had to initially talk to people on the phone - sometimes a few times and then they had to visit people. Again they had to visit some families several times before they would agree.

One of the Somali researchers said that the Somali community was 'always concealing something'. Generally, the coordinator, who is not Somali finds the Somali people more open than British people in many ways but sometimes you have to ask about the meanings of particular words before there is clearer understanding. This can take time but considering the topic of this research this is understandable.

8.8 General points about the focus groups

The parents group for non service users was quite a difficult group to manage. They refused to sign the core data forms and did not want to be taped, asking whether the researchers were employed by the CIA etc. Some members had unresolved issues which dominated the discussion. Many Somali people when engaging with a particular service or someone who they perceive as an authority figure may talk about unrelated issues. However, there is a need to remember that these issues are important to them and tend to be day to day issues. People are looking for answers and advice and if they have found it difficult to engage with services or are unsure where to go they will keep trying until they get the help they need.

The girls' focus group seemed to be harder work than the boys. The boys seemed more open in offering their opinions and views, although they weren't always open about whether they were talking about themselves or other people. The girls needed to be probed a lot more. Not sure why this was.

The young people were more open when talking about mental health. One service provider talked about inter-generational trauma. The researchers also said that the older people did not want to talk about what had happened in Somalia. For many this was the past and did not need to be talked about. Another Somali person who was a service provider said that people were more worried about everyday practical issues and did not have time to talk about their emotional needs. He also felt that a lot of these needs would go if the practical problems were resolved.

9 Recommendations

There are a number of practical recommendations that this research is able to make. These are listed below, and are linked to the 3 building blocks of the DRE, which aim to deliver equality of access, equality of experience and equality of outcomes.

However, it was apparent from the research that mental health issues take place within a particular context, and stressful life situations such as poor housing, poverty, overcrowding, debt, language problems and other specific issues all have a clear impact on mental health and vice-versa. Thus mental health symptoms may have unequal priority with these competing demands, while also being contributory.

The following are recommended:

9.1 In relation to more appropriate and responsive services

- achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees, and children.

- Induction for health and education professionals who will work/already work with Somalis on a regular basis to introduce issues of culture, beliefs and experience that impact on emotional well-being and mental health.
- Use of the Multi Agency Panel process which can coordinate a wide range of services, beyond the immediate sphere of mental health, but including those other services which have been found to have a significant effect on emotional and mental well-being.
- Race Equality Cultural Competence Training (RECC) for all CAMHS staff.
- Training for interpreters and professionals, covering how to best work effectively together to maximise communication between individuals,

families and mental health workers. In addition, some training in mental health for relevant interpreters.

- A review of how language barriers are being tackled in schools and primary health care - both between teachers and pupils and communication with parents. It is clear from the research that difficulties with language and communication hamper effective and appropriate care.
- Develop pathways to ensure that views and experiences of young Somali service users are fed into planning and service development.

9.2 In relation to community engagement

- delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers across England.

- A “cultural induction” in schools for newly-arrived pupils. This is based on the observation of some of the respondents who indicated that ‘knowing the rules’ and finding out ‘how the school system worked’ was difficult and would appear to be found out more or less by trial and error. An induction and assessment unit operates in Fishponds, as part of the Ethnic Minority Achievement Service (EMAS) and EMAS may be able to facilitate this. Such a move would reduce stress experienced by young people and aid smooth transition to school life in the UK.
- Education of the Somali community about mental health issues. Whilst this runs the risk of criticism of enforcing a particular paradigm (i.e. Western, psychoanalytic tradition) of mental health, knowledge of how mental health is treated in the UK would almost certainly be valuable and can be imparted without cultural imperialism. It is proposed that this is conducted as part of the CDW programme of work, and includes dialogue with all relevant sectors (including elders) of the Somali community. This should include discussion of how young people’s mental health issues can be approached.
- Parents and newly arrived young people’s lack of English language skills were identified as a major barrier to engagement with services by young people, parents and professionals. Availability and accessibility of English Language courses for newly arrived children and parents may be an issue. The group were unsure how to take this forward, but wanted to flag this issue as important.

9.3 In relation to better information

- from improved monitoring of ethnicity, better dissemination of information and good practice, and by improving knowledge about effective services. This includes a new yearly census of ethnicity of mental health patients.

- Somali parents need education regarding the school system in Bristol and where to go for help when things don't go well. It was highlighted during the research that in the Somali school system, the parents responsibilities effectively end at the school gate and the teacher takes over. In the UK there is more of a shared responsibility, and this needs to be made clear to Somali families arriving in Bristol in order to minimise stress and potential conflict. Possibly EMAS could be further engaged in this role.
- An outline of perceptions of mental health and available treatments should be included in health sections of relevant courses and training such as Citizenship training and ESOL .
- Information on service use by ethnicity should be fed back into services to help inform service planning and commissioning.

Finally, this research has specifically *not* addressed the issue of khat use in the Somali community. However, further studies and professionals working with the community should take note of previous work (Ismail and Home 2005) regarding this subject and its implications for mental health.

10 Appendices

10.1 Steering Group Membership and Terms of Reference

10.1.1 Membership

Name	Job Title / Organisation
Sue Topalian (Convener)	Bristol CAMHS and Joint Commissioning Development Officer, Bristol PCT and BCC
Alison Cameron	EMAS Induction and Assessment Team Manager, Bristol City Council
Joanna Hicks	Senior Support Worker Community Engagement Project, University of Central Lancashire
Latif Ismail	Transparency Research
Mo Ismail	Headteacher, Amana Education Trust
Anne James	Principal Equalities Officer, Equalities and Community Cohesion Team, Bristol City Council
Faiza Khaliq	Community Development Worker, Avon and Wiltshire Mental Health Partnership
Lynn Maddern	Clinical Psychologist North Bristol NHS Trust
Lorraine Millard	Young Peoples Health Development Worker, Community at Heart, (Lawrence Hill and St Philips Youth Partnership)
Mohamud Mumin	Local Researcher, Community Engagement Project
Marcel Osbourne	Community Development Worker, Barton Hill Settlement
Mark Patterson (replaced by Miriam Morgan)	Regional Race Equality Lead, Care Services Improvement Partnership (CSIP) South West
Ruth Pickersgill	Equalities and Inclusion Manager, Children and Young peoples Services
Claudette Radway	EMAS Manager
Lindsay Wall	Coordinator of Bristol Community Engagement Project, Transparency Research

10.1.2 Terms of Reference

Purpose

To provide direction and support to the Bristol Community Engagement project, and to enable the outcomes of the project to contribute to local service planning.

Terms of Reference/Tasks

Ensure that the work undertaken is relevant and important and fits with local priorities, and that the recommendations of the work are taken forward into local service planning.

Provide contacts and information to the project manager as requested to facilitate the progress of the project.

Help the project staff to shape their recommendations so that they can be picked up and implemented locally through local planning processes for children and young people at the end of the project.

Check and advise on ethical issues which may arise in the course of the work.

Maximise opportunities to sustain the impetus created by the project to improve services for Somali young people with emotional and psychological difficulties.

Membership

Specialist CAMHS Clinical lead on BME developments (NHS Provider Trust)

CAMHS Commissioners' representative (Bristol PCT and Bristol CC)

Induction and Assessment Manager (Bristol CC)

Equalities and Inclusion Manager, Children and Young Peoples Services (BCC)

Representative from Amana Educational Trust

C E Project manager from Transparency Research

Community Engagement Project Support Worker (University of Central Lancs)

South West Race Equality Lead (National Institute for Mental Health Excellence)

Young Peoples Health Development Worker, Community at Heart, (Lawrence Hill and St Philips Youth Partnership).

Chaired by CAMHS and Joint Commissioning Development Officer

Accountability

Transparency Research and Amana Education Trust will be accountable to the Steering Group for delivery of the project. The Steering Group will report back to the Bristol joint agency CAMHS Commissioners and Stakeholder Groups, through the Commissioner representative on the Steering Group.

Frequency and Dates of Meeting

The Steering Group will meet 2 monthly.

All meetings will take place in Room 221a at Bristol City Council House 10.30 to 12 noon. All are on Thursdays.

Meetings

July 26th 2007: Consider research tool and input into ethical issues

September 27th 2007: Update on research progress
November 29th 2007: Analysis of findings
January 10th 2008: Looking at the report
March 13th 2008: Planning a launch event and use of findings
May 8th 2008: Continuing use of findings

10.2 Notes on Somali Culture

Every culture encompasses a spectrum of people, and regional and individual expressions of that culture may vary widely. Below are some generalizations about Somali cultural values that may help you better understand and relate to Somali colleagues and community. Keep in mind, however, that not every Somali person will subscribe to all of these values, and the degree of influence these principles wield will vary from person to person.

- Extended family and respect for elders and authorities are valued over individualism.
- Interdependence is valued over independence.
- Relationships are valued over punctuality.
- Tradition is valued over being up-to-date and cutting edge.
- Strength and pride are valued over humility and self-effacement.
- Loyalty is a strong moral principle, extending to family, clan, and friendships.

Communication and Dress

- Saving face is an important cultural concern, as is the protection of family honour.
- Somalis view destiny as predetermined by Allah rather than controlled by the individual.
- Men are the head of the family. Although Somali women tend to have more education and independence than women in other parts of the Muslim world, equal gender rights is not a goal of Somali culture.
- Generosity is highly valued and is expected of all Somalis. Generosity as a way of life has been an important factor in the survival of the people. Many Somalis regularly send money back to extended family in their home country.
- Because of the Somali respect for strength and pride, boasting is generally not considered socially inappropriate as it is in the West.
- As with many African and South American cultures, Somalis may speak at a louder volume than is generally considered appropriate in the UK, particularly when they are talking to each other. A British listening to a group of Somalis talking amongst themselves may interpret the discussion as a heated argument, when they are simply having a friendly conversation.
- Somalis can be very expressive, and often use sweeping arm movements to express themselves.
- Somalis do not often express appreciation verbally.

- Poetry and oral tradition have a place of honor in the nomadic Somali culture. Somalia has produced many great poets, and the oral culture continues to flourish among expatriate Somalis.
- Political poetry also plays an important part in Somali culture.
- Western dress is common in urban areas of Somalia. Traditional Somali dress comes in many styles, varying by region.
- Traditional Somali dress is influenced both by the desert climate of Somalia and by Islamic values.
- Islamic principles of modesty require men to be covered from neck to knee and women from neck to ankle in non-form-fitting clothing.
- Traditionally only unmarried women wear headscarves, but as more people become devout Muslims, more Somali women are wearing head coverings.
- Henna is used to paint elaborate designs on women's hands or feet, generally in celebration of special occasions such as weddings.

Naming, Clans, Religion

- The Somali system of naming is different from the Western system.
- Western names: First (individual) + Middle (individual) + Last (family)
- Somali names: First (individual) + Father's first name + Grandfather's first name
- Because of this naming system, husbands, wives, and children will all have different last names.
- First and middle names are generally used for identification rather than first and last, which may lead to some confusion in Western societies. The person you know as Hodan Mohamed may be known in her own community as Hodan Ibrahim.

Somalis have been Sunni Muslims since the inception of their nation centuries ago, and Somali culture is inextricably entwined with Islam, affecting diet, dress, and daily routines. Although Somali observance of Islam is traditionally fairly casual.

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