Somalis and Mental Health: Raising awareness and developing interventions that improve outcomes

Fig. 1: Mental health conference organised by CSO ON 27th of March 2017 (Source: CSO).

Today has been fantastic; various speakers who are specialists in key areas with mental health and particularly in the Somali community have presented… it has been quite enriching and I will be taking quite a lot back…and how we as a community can work together with professionals in order to advance the needs of our community

(A community practitioner)

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EXECUTIVE SUMMARY

The British Somali community profile

- The community is complex, heterogeneous and is one of the largest black and ethnic minority groups in Britain, yet it is often treated as invisible or portrayed in negative stereotypical ways.
- Sections of the media in particular associate Somalis with gangs, extremism, piracy, welfare dependency, criminality, and harmful cultural practices like FGM, which affects community members psychologically, emotionally and socially.
- Limited understanding of the community's specific health needs has disadvantaged it from getting access and benefitting from mental health services.
- Islam is the central point of the community's identity.
- Transnationalism is another feature as expressed through for example remittances.

FINDINGS

Mental health in the context of Somali culture

- It is impossible to provide an agreed definition of mental illness in the context of Somalia since different regions use different words and expressions. However, two of the common expressions used across Somalia are *cudurka dhimirka* (mental illness) and *waali* (madness).
- Waali is irreversible or incurable.
- It is very difficult to translate Somali terms of mental illness into other languages.

Causes of mental illness in the cultural context of Somalia

- Causes include God's will, poor practice of religion, evil eye, evil spirit, and sorcery.

Traditional treatments of mental illness in Somalia

- People with mental illness are treated through religious and social support (e.g. family and clan) including methods and ritualistic dancing.
- Ziyara (visiting) local shrines or a living wali (a friend of God) are also used as healing.

The concept of mental illness from the perspective of the diverse British Somali community

- Though there are some significant differences in opinion and approaches when compared to traditional thinking, some perceptions and attitudes continue.
- Mental health is perceived as alienating and continues to general attract stigma; therefore, several respondents at the conference preferred to use either "stress management" or "emotional wellbeing".
- Though the label mental illness contains many diverse illnesses, the dominant labels when it comes to mental illness are limited and expressed as the individual with mental illness as being either "naked, crazy and/or mad". In line with bivalent thinking on this matter, people are either categorised as either "sane" or "insane" and nothing in between.

The causes of mental illness in UK

- Main factors can contribute to someone developing mental illness. These can be grouped under useful headings related to migration and resettlement/integration; racism linked to three traits: skin colour, ethnicity and religion; unemployment and welfare dependency, isolation caused by language difficulties in the case of the older generation and new arrivals, youth identity crises, poverty including housing issues, lack of useful networks within and outside the Somali community.

Challenges facing British Somalis with mental illness within the community

- Stigma and labelling.
- Disrespecting and ignoring.

- Accusation of being not good practising Muslims

Barriers preventing from seeking help

- Lack of mental health literacy and suitable information about the availability of local mental health services.
- Culturally less informed practitioners.
- Shortage of well-trained Somali professionals in the sector of mental health and autism (which is a learning disability and not mental illness).
- Fear and negative speculation about mainstream mental health services/systems.
- Culture of silence particularly among men.
- Stigma and fear of being labelled.
- Language difficulties.
- Religious misinterpretation including a lack of respect.

Best ways to improve the condition of mentally ill people

Establishing a community advocacy group for mental health

- Establishing community specific treatment centres and programs accompanied by recruitment and training community representatives in the sector of mental health.
- Developing parenting programs that adequately take account of cultural and religious diversity.
- Utilising Somalis' oral tradition as a healing method.
- Utilising Islamic teachings as preventative factors of mental illness.
- Transforming community attitudes and perceptions of mental illness by encouraging culture of expression and acceptance.
- Public awareness about mental health.
- Recruiting peer groups and siblings to assist children with mental illness.
- Transitional programs for students from year 6 to year 7 nd from A levels to universities which will explain differences between two stages and reduce pressures from the new learning environment.
- Establishing elderly community programs focused on wellbeing.

- Establishing purposeful programs for community prisoners through which they are reconnected to the community soon they are released.
- Culturally appropriate identification, diagnoses and assessment process.
- Promoting health equality.

Autism

- The concept of autism does not exist in Somali language.
- Some Somalis see autism as hyperactivity and it is a matter of time when it will disappear.
- Autism is widespread in the British Somali community and its lack of diagnose could be due to other issues -- prolonged civil, immigration and resettlement traumas – as being used to interpret and understand behaviour.
- Some Somalis associate autism with God's will and only the God can take it away. And for that reason, religious treatments are mainly used to cure autism.
- Some Somalis continue to link it to evil spirit possession or influence.
- Many Somali British families do not seek help because they do not understand it.
- Some Somali British families do not trust the mainstream social services because of fear that their children will be removed.
- Siblings who grew up in UK are said to be very helpful to their brothers or sisters with autism compared to parents and older generation.

The dilemma of former khat users

- Khat use is associated with mental illness.
- Some participants shared that it is still available on the streets of London as an illegal drug and its price is skyrocketing. The phenomenon has been driven underground.
- Khat was banned but a proper and gradual rehabilitation strategic plan is not in place, and therefore many former khat users from older generation are in limbo. These older men who were already vulnerable have further been marginalised.

Best ways to help former khat user recover and rebuild their lives

- Develop community based programs for former khat users in which local imams, and community health practitioners are involved.
- Establish community khat rehabilitation centre.
- Collect the stories of former khat users after the ban of khat in order to learn directly from their experiences and provide them support relevant to their needs.

INTRODUCTION

This report is based on one day conference organised by Council of Somali Organisations 27/03/2017. Over 100 people participated, consisting of professionals and practitioners from health and health related areas. Other stakeholders included social workers, grant makers, service providers, community leaders and activists, and grant makers. Relevant literature has also been reviewed. The vast majority of attendees were from the British Somalia community. The conference was entitled "Somali Mental Health Day: Raising Awareness and Developing Interventions that Improve Outcomes". This report employs both descriptive and analytical methodologies.

Before turning to the report findings, a brief profile of the British-Somali community is provided. We also include a brief survey of the literature on mental illness in the context of Somalis in Britain and Somalia. Somali terminologies and expressions of mental illness in the context of Somali culture in Somalia; the causes of mental illness in Somalia and treatments strategies; will be shared.

The main report finding begins with British-Somali community's understanding of the concept of mental health. Similarly, participants' perspectives regarding the causes of mental illness within the community as well challenges facing them will be explained. Barriers preventing Somalis from seeking help will also be discussed: barriers include poor mental health literacy and availability of suitable information; culturally less informed practitioners; a shortage of well-

trained professionals and interpreters from the community; fear and negative speculation about the agenda and usefulness of mainstream mental health services; culture of silence particularly among men will be discussed.

After that, the report explores participants' points of views and suggestions toward the best ways to improve conditions of mentally ill people such as establishing a community advocacy group and community specific treatment centres accompanied with recruiting community representatives, developing culturally sensitive parenting programs, utilising Somalis' oral tradition and Islamic teachings as healing and preventative methods, transforming community attitudes and perceptions of mental illness and encouraging culture of expression, public awareness, recruiting peer groups and many other ways of improving the situation of those with mental illness.

The report will also briefly discuss autism: the challenges and perception of treatments within the British Somali community; issues related to the condition of former khat users and the best rehabilitation strategies to help them recover and rebuild their lives will be summarised. Finally, we conclude the report with recommendations and references that readers can follow up to get a fuller understanding.

METHODOLOGIES

The report employed descriptive and analytical methodologies. Descriptive method is a fact finding enquiry that describes the knowledge, view, information and perspectives of the participants presented during the conference, with special emphasis on frequent views, experiences and common themes. During analysis, the researcher uses facts, views, experiences and information delivered and shared by participants in order to capture and explain the current situation of mental illness and autism as well as the situation of former khat chewers within the British Somali community in London (Kothari, 2004, p. 2). Data

obtained from the conference were coded and grouped into key themes. An "emic" perspective was adopted in order to ascertain the views and experiences of the conference participants were presented (Patton, 2012).

THE BRITISH SOMALI COMMUNITY PROFILE

The British Somali community is one of the largest black and ethnic minority groups. It is also the largest Somali community in Europe and in the West. The community is very diverse but is often described as hard to reach or silent and very little is known about them (Open Society Foundations, 2014). In terms of social composition, the community consists of many waves of immigrants and subsequent British or European-born generations. There is evidence to demonstrate that Somali men fought alongside British troops in the battle of Trafalgar in 1805 and therefore these Somalis formed the oldest Somali settlers in the western world (Muir, 2012). Early immigrants to Britain included seaman or *lascars*; they arrived in the nineteenth century in port cities like Cardiff, with some choosing to settle. Post world war two Somali immigrants like other Commonwealth citizens from South Asia and the Caribbean islands arrived for economic reasons. Another wave of immigrants arrived as refugees who fled from protracted civil war that began in the late 1980s. A further wave of Somalis have arrived and settled in Britain from European countries.

According to the last census (2011), there were 99, 848 Somalis in Britain. 65,333 recorded themselves as living in London. However, these figures are contested, in large part owing to no specific Somali ethnic category option in the 2011 census. The figure of near 100,000 indicates only the Somali born population and does not include subsequent British or European-born generations. Thus, the number of British Somali community is greatly under-estimated (Open Society Foundations, 2014). Some estimates put the figure between 300,000 and 700,000 people. Given the tendency for Somalis to have large families as well as the high fertility rate among women, it is very hard to know the level of the internal growth of the British Somali population (Muir, 2012).

Alongside the lack of statistical data, limited understanding of the community's specific health needs has disadvantaged the community from getting access to mental health services. There is a strong evidence of poor health in the community including high levels of mental illness, infectious diseases, diabetes, hypertension and cardiovascular disease. Further health difficulties are created by the lack of cultural sensitivity and awareness on the part of medical staff, a lack of interpreters and British Somali staff working in the NHS, and due to instances of miscommunication and misdiagnosis (Open Society Foundations, 2014: 18).

In terms of media representation, the community is hugely misunderstood and covered negatively depicting young British Somali men as prone to gangs, and violent culture and extremist religious groups. FGM, piracy and welfare dependency are also covered overwhelmingly and negatively. All these issues affect the community leading to stress, anxiety and mental illness. For the public service, the community experiences a significant inequality in the service provision including health, education, and employment (Open Society Foundations, 2014).

Regarding belonging, religion is a central to British Somali identity and belonging. Clan identification, strong family ties and networks of reciprocity are very essential for Somalis, particularly the new arrivals. However, the politics and power struggles in Somalia have had a negative impact on the coherence of the community (Casciani, 2006).

FINDINGS

Mental illness in the context of Somali culture

Western health practitioners often encounter many challenges when providing assistance to Somali migrants and refugees with mental illness or psychosocial problems due to poor understanding of Somalis' distinct cultural and religious conceptualisations of mental illness and psychosocial problems (Cavallera, et al. 2016). It is almost impossible to provide an agreed, and a fully coherent, overview of Somali terminologies regarding mental illness. This is because different regions use different terms for mental illness. It is also very hard to translate Somali words dealing with mental illness to other languages yet Somali speakers can easily understand the meaning of the words indicating mental illness in their specific- cultural contexts (Cavallera, et al. 2016).

Somali terminologies for mental ills include *xanuunka madaxa ama maskaxda,* which translated means 'head illness or brain illness'. In the Somali context this term also is used to express that someone has mental illness. Somalis also use clearer terminology, for example, *cuduradda dhimirka or cudurka dhimirka* to express that someone has 'mental illnesses or mental illness'. The most common word used across Somalia is *waali* that in its most severe meaning indicates madness/craziness that cannot be reversed or cured. The table below states some common expressions/words which indicate different levels and types of mental illnesses.

Table 1: Somali Language and Mental Health

SOMALI	ENGLISH
Cudurada dhimirka	Mental illnesses
Waali	Madness/craziness (reversible)
Murugo	Depression/sadness/ sorrow
Welwel/welbahaar	Anxiety
Walaac	Stress/worry
Tiiraanyo	Trauma/grief

Isla-hadal/iskubuuq	Talking alone to oneself
Mirqaan	Feeling high
Buufis	Blown up/bloon with air
Waswaas/hawas	Obsession/mania/compulsion
Daal	Fatigue
Maseyr	Jealousy
Saar/mingis/boorane/wadaado/ ardooyin/ rooxaan	Spirit possession

(Omar, 2017).

Causes of Mental Illness in the Cultural Context of Somalia

Explanations of mental illness in Western context such as biochemical imbalances, a response to trauma, individual vulnerabilities or learned behaviour are unknown among Somalis in Somalia (Cavallera, et al. 2016). Among Somalis, the main causes of mental illness could be the following:

Table 2: Causes of Mental Illness in the Cultural Context of Somalia

Somali	English
IraadoAlle	God's will (Pre-destination)
Ku dhaqanla'i' diin	Poor practices of religion
Jinns	Evil spirits
IL/Cayn	Evil eye
Habaar/inkaar	Curse from someone e.g. parents
Sixir	Magic/sorcery
Qaad/Jaad	Khat
Maseyr	Jealousy

(Omar, 2017)

Traditional Treatments of Mental Illness in Somalia

As explained above, the causes of mental illness are much more associated with religious dimensions e.g. God's will and poor practices of Islam; social relations e.g. evil eye, cursing; and other spirits such as jinns. Muslims are culturally heterogeneous and therefore they practice Islam in different ways when it comes to mental health issues and healing (Rassool, 2000). Therefore, since mental illness in the context of Somali have religious, social and spiritual aspects, people with mental illness are traditionally treated, supported and healed through social networks, religious treatments and ritualistic traditional dances. Religious healing is particularly important for Somali people. This is because Somalis tend to very religious. Religious healings through *duas* (blessings), *taxliil* (holly water), *qardhaas* (amulet), *dukashada salaada* (performing 5 prayers), *soonka* (fasting ramadan), *sakada* (giving charity), *xajka* (going to pilgrimage), and reading the Quran on patients are very important for Somalis and are the most widespread healing method for mental healing (Johnsdotter et al, 2011.).

Furthermore, in Somalia, there is an Islamic tradition of *ziyara* that is associated with spiritual medicine and religious healing. In *ziyara*, people visit their local shrine or a living *wali* (a friend of God/Saint in western perspectives.) Some Somalis believe that *ziyara* or *wali* can heal people affected with *jinn.* The existence of *jinn* is explained in the Qur'an and is an article of faith. For that reason, Muslims are obligated to believe the existence of *jinns.* Some Muslim scholars have explained that *jinns* can cause harm to human beings (Johnsdotter et al, 2011.) Therefore, from the Islamic perspective, religious therapists can heal people from *jinns*, evil eye or *sexir* (sorcery/black magic) (Johnsdotter et al, 2011: 744.) Tuncer (1995) explains that "[s]pecial words or prayers or the Quran may be used both preventatively and as therapy against mental illness. Chaining patients is also used as the last method when person with mentally illness becomes aggressive and uncontrollable and all other means are exhausted.

Regarding social treatments, family, clan and community support for Somalis with mental illness has been found to be essential (Silveira and Allebeck, 2001). Interestingly, Guerin (2003: 6) found that collective social activities used by

Somalis to discuss past and present troubles could promote mental wellbeing. These social events are perceived by many mental illness therapists as "early interventions" for social and mental well-being (Johnsdotter et al, 2011).

The concept of mental illness in the perspectives of the British Somali community

Participants in the CSO conference highlighted the importance for mental health practitioners, policy makers and service providers to understand the perspectives of the British Somali community when it comes to mental illness and autism in order to develop relevant policies and practices. Several participants reported that the term "mental illness" in and of itself is alienating and problematic and therefore recommended adopt the terms of "emotional difficulties", "emotional wellbeing" or "stress management" instead of mental illness or mental health.

Some participants argued that the concept of mental illness is very confusing. Among many Somalis 'mental illness' continues to be seen or expressed as madness or craziness, which is a continuation of the cultural definition of mental illness back-home in Somalia. These Somalis tend to perceive mentally ill persons as persons who run away nakedly; persons who shout and kill people without reason. Therefore, people without the abovementioned attributes, attitudes, and symptoms (running nakedly, shouting and threatening to kill people) cannot be described as mentally ill people.

Several participants at the conference saw metal illness in only bivalent ways; from this perspective you are categorised as either normal or not normal and nothing in between exists. Accordingly, people are either sane or insane and there are no grey areas. And therefore, many community members –who have developed mental illness–are unaware of having mental problems as long they are not running unclothed, or not yelling or harming others.

However, there were other views indicating that some British Somalis particularly including professionals with good education have learnt different concepts of mental illness after their resettlement in Britain. Differences in approach and attitudes also diverged according to generation and age.

The causes of mental illness in UK

While causes of mental illness in Somalia were mainly attributed to God's will, evil eyes, jinn influence and possession, black magic, sorcery, witchcraft, lack of practise of Islam, parents' curse and so on, these 'causes' have been challenged and problematised by members of the British Somali community. British Somalis link mental illnesses to other causes including genetics and environmental factors. In particular, stress and emotional difficulties related to unemployment, racism, housing, lack of useful networks within the Somali and mainstream communities, language barriers, culture shock and youth identity crises. They also highlighted how anxiety and stress related to family reunification caused significant problems. Issues related to migration and sponsorship of family members in Africa, predominantly wives/husbands and children. There were also issues related to divergences in family practices and related values, including different child-raising practices, lack of support from extended family members, and lack of community support that was common back-home. Additionally, the shortage of successful role models, together with tribalism, the impacts of prolonged civil war, pressures from the country of origin and substance abuse such as illegalised khat use are explained to be stressor-inducing factors and causes of mental illness in the context of Britain and the West more broadly.

Challenges facing British Somalis with mental illness

The vast majority of conference participants concurred that stigma is the biggest challenge. Though labelling and stigma attached to people with mental illness is rather common among other societies, it is more intense and more evident in communities that hold the kinship network in high regard. In a nutshell, people with mental illness are stigmatised and accused of being incurable. Illness is seen as being precipitated by individuals not being good practising Muslims. Their families are also stigmatised and accused of not raising their children properly and in Islamic ways. Nevertheless, people with mental illness are ignored by the

mainstream community members and they are not talked to, assuming that they are worthless, and their talk is nonsense and waste of time

Barriers preventing from seeking help

Participants identified many barriers preventing community members with mental illness from seeking help from the mainstream mental health services, as well as community services. These barriers included: lack of mental health literacy and suitable information about the availability of the mental illness services; culturally less informed practitioners; shortage of well-trained professionals and interpreters from community in the sector of mental health; fear and negative speculation of the mainstream mental health services/systems; and culture of silence particularly among men. The followings are the details of these barriers

Lack of mental health literacy and suitable information about the availability of the mental illness services

Many Somalis expressed that they benefitted little from mainstream mental health services. This is because the vast majority of the community population is unaware of the mental services available. Additionally, lack of reliable and authentic information about mental health services was a barrier to seeking help from relevant mainstream services. Conversely, information about mental health issues circulated in the communities was mainly based on negative rumours and speculation, which created fear and scepticism in the community. Therefore, instead of using mainstream services, they may turn to familiar treatments such as family and relative support or traditional and religious treatments. Some participants in the conference believed that Somalis do not use the mainstream services because they do not see any evidence showing that people with mental illness have not been healed through using mainstream institution treatments. Lack of awareness and proper understanding of the consequences from untreated mental illness or autism within the community is also widespread.

More importantly, some participants stated that Somalis in general do not perceive counselling and talk therapy as a useful means of treatment. Instead, Somalis do expect from mental health and autism practitioners some practical intervention, prescriptions and cure similar to prescriptions given through tangible medicine by doctors as they do in the case of physical injuries. Other participants felt that the mental health services were designed for the mainstream British people who were culturally and religiously different to Somalis and, therefore, the mainstream approach of mental illness treatment is irrelevant to the Somali culture.

Culturally less informed practitioners

During the conference, some participants uncovered that there was very limited understanding among professionals over how to culturally and sensitively respond to the community needs regarding mental illness and autism. Moreover, many mainstream practitioners did not give any consideration to African perspectives and practices of mental illness. Therefore, the treatment within mainstream institutions is perceived to be at best a one way process. Consequently, many Somalis, specifically the older generation did not seek help from mainstream mental health practitioners whom they feel would not understand or respect their beliefs, feelings, and views; or that they did not respond to culturally a sensitive ways during treatment processes.

Because of lack of cultural understanding, the mainstream mental health practitioners often misunderstand the communication style of Somalis and interpret these at times as being indifferent, aggressive or even signs of mental illness. For instance, culturally, Somali people talk loudly using body language that is different and, therefore, western mental health practitioners may interpret wrongly and misunderstand these as symptoms of mental illness which, in reality, is actually a cultural style of communication.

Shortage of well-trained professionals from community in the sector of mental health

The issue of culturally less responsive mental health practitioners from the mainstream services was compounded by the lack of well-trained community representatives who can equally understand both the mainstream and community approaches regarding mental health and autism. It is believed that if such representatives from the community are recruited, a lot of Somalis with mental problems will contact them and seek their advices and help.

Shortage of well-trained Somali interpreters in the field of mental health

Several practitioners who attended CSO's mental health conference took the view that many interpreters are unfit and unfamiliar with the mental health field and therefore they may misinterpret and become barriers for Somalis when it comes to seeking help. Some interpreters have poor understanding of the issue of mental health and therefore they are unable to interpret or translate properly or they may distort patients' information and interviews as well practitioners' advice when interpreting. As an example, a patient may elaborate about his/her condition and then the interpreter may summarise in one or two short sentences because of a lack of understanding of the terminology or she he/she may feel embarrassed to interpret some things they don't like which could be meaningful and perhaps the most important for practitioners to know.

Right interpreting leads to right understanding, right diagnoses and right assessment and vice-versa. Conference participants' view is in line with Open Society Foundations' (2014, p.18) findings which explained that British Somali community's health difficulties are compounded by lack of cultural understanding and awareness from the UK medical staff, and scarcity of interpreters and British Somali staff in the health sector particularly in the GPs and miscommunication and cultural misunderstanding which may entail misdiagnosis, wrong assessments and therefore improper treatment process. Interestingly, some young participants in the conference argued that many

interpreters lack of emotional understanding, and empathy when dealing with mentally ill people.

Fear and negative speculation of the mainstream mental health services/systems

There is perception in the community that white mental health practitioners perceive mentally unwell Africans particularly men as violent and dangerous to societies and, therefore, if African men with mental illness submit to mainstream mental health services practitioners will give them injections in order to calm them down and in order to protect wider society. Additionally, it is believed in the community that these injections would increase the level of madness instead of healing. This argument is endorsed by recent research findings (Omar, et al. (2015) that focused on mental health conditions of the Horn of African Muslims particularly Somalis in Melbourne, Australia.

Culture of silence particularly among men

A culture of silence and high secrecy was identified as a factor that hinders Somalis particularly men from seeking help and support from the mental health services. African men are in general reluctant to talk about their health difficulties or admit their mental problems until they can no longer hide them. Instead, they hide their problems even from their wives as well as from others. The reason behind is that they fear accusations of being 'weak'. Our participants' views are in agreement with Cinnirella's and Loewenthal's (1999) and Johnsdotter's (2011) research findings.

Other barriers identified included stigma, labelling, language difficulties, religious misinterpretation, ghetto residence where good services are not available, feelings of being isolated and irrelevant.

Best ways to improve the condition of mentally ill people

Conference participants argued that the biggest resource and the most protective factor of mental illness that the community has is its people and Islamic values and, therefore, it is important to inspire, empower, guide, direct, and train relevant community stake holders on how to collectively utilise its social strengths, values and human capital. Somali society has very strong ties of kinship, and extended families as well as strong practices of Islam which can offer enormous help to mentally ill people and their families. This view is endorsed by Scuglik et al (2007) findings. Some participants advised that religious healing such as improving spirituality should be cultivated, developed and promoted and that would contribute to the general wellbeing of community members including those with mental illness and their families. Equally, participants suggested the importance to urge policy makers and service providers to support, and provide funds and resources to community organisations, centres, and programs in order to enable the community to develop proper mental illness and autism treatment services.

The mains strategies and ways identified by CSO participants included: establishing a community advocacy group and community specific treatment centres accompanied by recruiting and training community representatives in the sector of mental health; developing parenting programs in culturally diverse society; utilising Somalis' oral tradition as a healing method; utilising Islamic teachings as preventative factors of mental illness; transforming community attitudes and perceptions of mental illness by encouraging culture of expression and acceptance; developing public awareness; recruiting peers groups; developing transitional programs for students; establishing elderly community programs; establishing purposeful programs for community prisoners; culturally appropriate identification, diagnoses and assessment process; and promoting health equality.

Establishing a community advocacy group

Advocates should be trained and helped to take positions of responsibility enabling them to ensure the voice of the community is heard. They would be able to help shape policy through sharing relevant knowledge about community needs. These advocates it was envisaged would act as the bridge between the community, the mental health sector, and policy makers.

Establishing community specific treatment centres and programs accompanied by recruitment and training community representatives in the sector of mental health

CSO participants suggested the importance of establishing community specific treatment programs tailored to meet the needs of the Somali community. Participants recommended the necessity to recruit and train well-informed community representatives in this field. These representatives and community mental health practitioners would also alongside advocates act as a bridge between the community and the mental health sector and policy makers. This view is supported by previous studies which concluded that ethnic communities in Britain benefitted from well-informed practitioners including professionals from the same cultural background. This was also reflected in previous calls to establish "ethno-specific mental health provision" as a potential way to improve help-seeking strategies for mental illness in ethnic communities in UK (Cinnirella and Loewenthal, 1999, Omar, et al, 2017).

Developing parenting programs in culturally diverse society

Suggestions offered by conference participants included to develop purposefully designed parent programs which will enable Somali parents raise their children in ways relevant to culturally diverse British society. Such programs can enormously minimise parents-youth mental illnesses caused by inter-generational conflict and misunderstanding. Failure to address parenting issues could lead to family disconnections, unhealthy relationships, mistrust and

ultimately lead to stress, depression and mental illness. In addition to parenting skills, it the importance of creating partnerships and collaborative relationships between parents, community leaders, schools and professionals in the mental health sector was also crucial and will help to overcome conflicts and tensions.

Utilising Somalis' oral tradition as a healing method

A number of participants suggested that Somali patients with mental illness could effectively be treated through well-designed oral programs including *sheeko-xariiro* (stories), *gabay* (poetry), *murti iyomaah-maahyo* (wisdom and sayings), and *ciyaar Soomaali* (Somalis' ritualistic traditional dancing). These kind of artistic treatments suit Somali oral learning. At individual level, this tradition can also provide self-therapy, and self-talking healing strategies.

Utilising Islamic teachings as preventative factors of mental illness

Islam provides for the community, hope, positive thinking and spiritual strengths. Therefore, imams, religious teachers and Islamic scholars should be utilised and incorporated into treatment plans and therapies. Several participants recommended purposefully designed workshops in which mental health professionals and the imams and religious teachers could interact, and learn from each other by exchanging their experiences, and knowledge concerning mental illness as well as treatment processes.

Young women in particular expressed the view that women should play a greater role in addressing mental illness. Several participants suggested that women should be trained as professional Islamic counsellors, offering cross-cultural therapies. They could also be supported to develop their understanding of how to spot signs of mental illness and how to support patients to ensure positive outcomes. Many participants also expressed that women as 'insiders' (when it comes to female issues) have great empathy as well as opportunity to intervene, to relate, to enable and empower other women so as to improve outcomes.

Women within the Somali community are seen as crucial figures in the family and more broadly community life. Conference participants' views on women related mental health support has been confirmed by with Guerin (2003**,** p. 6) who found that Somali women in diaspora have successfully managed to create and organise social activities and new opportunities in order to discuss their past experiences, and present troubles which promote social and mental wellbeing. These social events were perceived as "early interventions" for social and mental wellbeing. Similarly, Halcon et al. (2004) reported that women were more likely to respond to stress, sadness, frustration and social problems by organising group social events whereas men tended to respond to their stress by physical exercises.

Some young participants in the conference stated that a lot of imams do not related to the young generation and do not know on how to effectively communicate with people seeking their support. This is because most mosques are run by members from the older generation who tend to lack a deep understanding of the needs, challenges and frustrations of young people. Despite the significance of Islamic healing within the Somali community and the Muslim communities in general, studies of imams who by definition were males in the USA found that imams have far less formal training in mental health compared to other religions. Only 5 out of 64 imams had some understanding of the relevant subjects such as psychiatry, psychology, sociology and anthropology (Ali, Milstein and Marzuk, 2005). This indicates the importance to train and improve the capacity Somali imams in Britain.

Therefore, similar to women, it has strongly been recommended to involve young people in mosques, and Islamic services since they can easily relate to young people with mental illness and autism and help them to access support.

In conclusion, literacy regarding services, types and tretments for mental illnesses required resources,a multi-prong approach that involved a range of stakeholders including imams, community leaders, and parents to assist those with mental illness.

Transforming community attitudes and perceptions of mental illness by encouraging culture of expression and acceptance

Some experts participated in the conference identified that women are in general, more likely to express their needs and seek help for mental health issues than men. This is not only within the Somali community but it is also a reality with other societies and cultures worldwide. Men are generally more likely to be reluctant to seek help and express their mental illness and, therefore, it was recommended that we encourage a culture of openness and expression of ones' feelings, frustrations, and weaknesses. As a result, they can be understood, helped and supported. They can also be assisted to understand their own mental illness challenges and helped to change these challenges into opportunities to improve their lives when moving forward.

Public awareness

Public awareness was a common theme mentioned by almost all participants. It was suggested that we organise more training and forums, public awareness events, and public educational programs for the wider community.

Transitional programs for students

During the conference, some attendees highlighted that when students move from year 6 to year 7 or from A levels to university, they need well organised transitional programs which educate them about the new settings. That will minimise the pressure and confusion associated with the new environment and the new learning approaches. Such transitional programs are seen as preventative of mental illness and educational dropouts.

Establish elderly community programs

Elders from refugee and migrant backgrounds encounter enormous challenges posed by resettlement experiences, language difficulties and culture shock which

could cause them anxiety, depression and emotional difficulties. Therefore, some participants were of the view to establish elderly programs in order to help them have active lives.

Developing purposeful programs for community prisoners

Some participants working with prisoners emphasised the importance of understanding, identifying, and acknowledging meaningful the extent to which convicts were suffering from mental health condition. They needed to be routinely assessed and offered suitable treatments. In order to help Somali prisoners it was crucial for families to support the rehabilitation of their relative. Often, to avoid stigma Somalis cut of ties with relatives who end up in prison but this often leads to worsening of mental health of those involved. One professional working in prisons stated that the action of writing letters to prisoners seems very simple but it does in his experience make a huge positive difference in the life of the prisoners.

Culturally appropriate identification, diagnoses and assessment process

Participants emphasised the importance of seeing the person suffering from mental illness holistically, in particular, when it came to diagnosis and treatment.

Promoting health equality

The existence of inequality in the health sector including mental health services is a big issue which required a long-term strategy. Somalis and their experiences and needs tend to be rendered invisible because of how ethnic data is captured by statutory service providers. The community must come together in solidarity to ensure that they engage with consultations that sees the recording of data which helps to build a more accurate picture of the degree of poor outcomes this community is experiencing compared to others and what interventions are needed to address this inequality.

The concept Autism

Fig. 2: Image of Nura Aabe who is a well-known British Somali mother with an autistic son. She is an advocate for children with autism in the Somali community in UK. She is also a researcher on issues concerning autism within refugees and migrants in UK. Nura is the founder of Autism Independence.
(Source: Rhodes, 2017) reporting to the British Psychological Society.

There is no Somali word for autism. This is because autism is historically and culturally unknown among Somalis as articulated by Ayan Yusuf in Bristol who is a mother of a son with severe autism:

> "I was living in Somalia many years ago and I've never heard about autism… The war it happened to me in Somalia. I was a young girl running around touching bullets on nose and I've never seen this kind of…[she

wipes tears]… I rather to live [with] war in Somalia" (cited in Jamal's report for channel 4, 2017).

Causes of autism

Nura Aabe who is a community expert on autism expresses the view that autism is a lifelong disability and nothing can take it away. She argues that research and statistics show that that autism is prevalent in the British Somali community but is often ignored or overlooked as parents often attribute symptoms to different factors including civil war and resettlement trauma. Those who do accept their child has a learning disability attribute its cause on trauma experienced by mothers during pregnancy, the types of food produced in this country and consumed by Somalis of whom their body is not familiar with and so on (ACTA community theatre, 2014).

Because of unfamiliarity, some Somalis may perceive autism as a hyperactivity disorder that will disappear as time passes while many others may include autism into *waali* (severe mental illness) caused by God or evil spirit. In that interpretation, Somali do accept what Allah has decided for them hoping he might help their child to improve in the future (National Institute for Health Research, 2016).

As recounted by Sheikh Hassan, who is, a British Somali religious healer living in London, "we believe that autism is an illness caused by Allah and Allah is the one who can take it away. That is what we believe… it is possible that these illnesses [autism] are evil spirits" (cited in Jamal's report for channel 4, 2017). Therefore, autism within the British Somali community is mainly treated through traditional and religious healing methods.

Fig. 3: Sheikh Hassan, a Somali religious healer in London (Source: Osman, 2017) reporting to Chanel 4, 17 February 2017.

Ayan's son is treated by Sheikh Mohamed Sharif who describes himself as a British Somali religious healer. Though Sheikh Sharif recognises the role of the modern mental health treatment, he equally believes the role of religion as a successful treatment by saying "The Quran is a fixer, filter, healer, treater and light. The Quran goes to the brain and the heart, the bones and the blood. [It] makes the person feel peace and calm" (cited in Jamal's report for channel 4, 2017).

Many British Somali families do not understand what autism is and therefore they may not seek help from autism health services while some may not trust social services, as they fear that social services may remove children from their families (National Institute for Health Research, 2016). This results in fewer Somalis being diagnosed and from receiving treatment which leads to poorer outcomes for them.

During the CSO conference, a leading expert elaborated on how to deal with children with autism. Parents needed more information and education about autism and about the best ways to support their children with autism. A crucial role could also be played by siblings. If siblings of the autistic child are assisted

and skilled on how to engage with their brother or sister with autism they could make a big difference in the life of the child with autism; alleviating the lack of action or inability among the older generation family members. Siblings who grew up in Britain tended to have a much better understanding of autism and are more helpful and understandable than parents and older generation.

The dilemma of former khat users

Fig. 4: Somali men chewing khat before it was banned in UK in 2014. (Source: Wardheer News, 2014).

Khat use is associated with mental and physical illnesses. Numerous studies found that chewing khat leads to mood instability, antisocial behaviours, personality disorder, unexpected attitudinal changes and family breakdowns (Omar, et al. 2012).

Several participants in CSO's conference argued that though khat was banned, it is still available in the streets of London as an illegal substance and the price is skyrocketing. A previous research conducted on hat use in the Somali Australian community in Melbourne (Omar, et al. 2012, p. 66) argued that if a proper and gradual rehabilitation strategic plan is not in place the prohibition of khat use

will likely lead to the criminalisation of an entire generation of older Somali men who are addicted to chewing khat. As a result, the criminalisation of khat use will shift the use of khat substance from legal to a hidden and illegal drug. And this will further marginalise the already vulnerable elder Somali men.

A former khat user who attended the CSO's conference explained that when khat was banned in the UK, khat users have been left behind and without any proper support to recover and rebuild their shattered lives. These former khat users are confused and standing around streets without knowing what to do or where to go and seek help. Therefore it is a very difficult time for khat chewers to participate in their communities, exercise their normal life and rebuild their future unless they are helped.

Best ways to help former khat user recover and rebuild their lives

Participants suggested the necessity to develop community based solutions for former khat user where local imams, community organisations like CSO and health professionals are involved. Similarly, it has been suggested to develop counselling and recovering programs for former khat users. Practical steps suggested included the establishment of khat rehabilitation community centres. Moreover, it has been acknowledged the usefulness to collect, and expose the stories and experiences of former khat users, their coping strategies and how their lives have been transformed since the ban of khat either good or bad. In the perspectives of former khat users, emphasis has been put on the importance to learn from former khat user's needs from their own perspectives in order to develop a model relevant to culturally appropriate rehabilitation services.

RECOMMENDATIONS (Mental health)

To the community

- Develop educational courses and awareness about mental illness
- Improve language capacities and general literacy of the less educated community members

- Develop community dialogue focused on mental health, autism and khat rehabilitation
- Develop purposeful parenting programs
- Promote mental health information within the community
- Encourage voluntarism and involvement in community activities as well as the mainstream activities
- Facilitate women and young people to participate in mosques, Islamic teachings and general Islamic activities in order to provide counselling and support for women and young people
- Encourage self-treatment strategies e.g. involvement in the community activities, sports, having person plan, and so on
- Develop community specific rehabilitation treatments
- Conduct further research.

To the government, mental health practitioners and service providers

- Provide resources and funding for community projects, programs and research related to mental illness and autism
- Create community specific employment opportunities
- Facilitate GPs-Mental health professional collaboration in order to exchange information and experience for the sake to support the community
- Develop culturally responsive mental health services for the community
- Offer cultural competency training programs to mainstream mental health therapists and GPs dealing with community patients
- Train members from the British Somali community with relevant knowledge and experience to mental health sector in order to bridge between the community the mainstream services
- Train professional interpreters with good understanding of mental health issues
- Develop community specific treatment centres
- Somalis are oral society and therefore, developing talk therapy with help a lot (Omar, et al. 2012).

RECOMMENDATIONS (Autism)

To the policy makers, service providers and the community

- Raise awareness of autism among the British Somali community
- Train parents the best ways they can cope and communicate to their children with autism
- Help parents with autistic child understand where they can get special social, educational and health support
- Identify earlier children with autism to assist as early as possible
- Conduct more research on autism with the British Somali community

RECOMMENDATIONS (Khat use)

To health practitioners, government, service providers and the community

- Adopt a health promotion strategy through education regarding the problems associated with khat use
- Develop community centres, counselling, and recovering social programs through which former khat users are assisted to expand their social activities and rebuild their lives
- Provide support through religious activities for those affected by khat use
- adopt universal harm minimization strategies specifically tailored to khat use (Omar, et al, 2015)
- Develop culturally sensitive intervention strategies that may use an outreach approach to former khat users
- Conduct further participatory research focused on the best strategies to help former khat users through which their needs are gleaned from their own insights and experiences.
- Encourage parents with child with autism to participate in Early Bird Course

CONCLUSION

This report was mainly based on the experiences, and insights of participants in CSO's conference. The report started with executive summary, followed by short introduction, methodologies and the profile of British Somali community explaining how complex, heterogeneous, and silent the community is. Similarly, negative media coverage of the British Somalis, and the limited understanding of the needs of community in terms of health and difficulties to get access to mental health services were highlighted.

Regarding report findings, the concept of mental illness in Somalia's cultural context, Somali terminologies used in mental illness, the causes of mental illness traditional and cultural treatments were highlighted followed by the British Somali community's understanding of the concept of mental illness. The terms of 'mental health or mental illness' were found to be problematic themselves and therefore it was suggested the use the terms 'stress management' or 'emotional wellbeing or emotional difficulties' instead of mental health or mental illness. In general, the dominating definition of mental illness within the community was 'madness or craziness".

About the causes of mental illness, participants found that the main causes were migration related stressors such as unemployment, culture shock, language difficulties in the case of the older generation and new arrivals, youth identify crises, housing related issues, discrimination against community's skin colour and religion, lack of useful network from the mainstream, and lack of understanding on how to raise children in culturally diverse society. Participants also found that people with mental illness or do face challenges within the Somali community such disrespect, stigma, ignoring and accusation of being are not good practising Muslims.

The report also summarised participants' perspectives and experiences regarding barriers preventing patients with mental illness from seeking help.

These barriers included but not limited to lack of mental health or autism literacy and suitable information about the availability of the mental illness and autism services, culturally less informed practitioners, shortage of well-trained professionals and interpreters from community in the sector of mental health, negative speculation association with the mainstream mental health services/systems and so on.

As a solution and the best ways to improve the conditions of people with mental illness, participants put forward several suggestions which have been summarised in this report. Some of these solutions and suggestions included: establishing a community advocacy group for mental health as well as community specific treatment centres and programs accompanied by recruitment and training community representatives and interpreters in the sector of mental health. Similarly, some of the solutions proposed were to develop relevant parenting programs in culturally diverse society; utilise Somalis' oral tradition as a healing method as well as Islamic teachings as preventative factors of mental illness. Transforming community attitudes and perceptions of mental illness by encouraging culture of expression and acceptance, organising public awareness and recruiting peer groups and siblings to assist children with autism were advised. Other suggestions and recommendations were to develop transitional programs for students, elderly community programs, and purposeful programs for community prisoners.

The concept of autism in Somali culture together with Somali community's understanding of autism and treatments strategies have been briefed. In conclusion the report tabled participants' views on the condition of former Khat users and the best strategic rehabilitation process in which they can be helped recover and rebuild their lives.

PARTICIPANTS' VOICES

The knowledge we gained from this conference will help us develop good model on how to deal with mentally ill community members said a police man who is a team member of police mental health initiative
(A police participant)

It is timely well organised. Mental health affects all of us in different communities but it affects the Somali community even more, partly because lack of confidence, lack of recognition, but also service providers are not fully [equipped]to meet the challenges and the needs of the Somali community. So, we are grateful [to] CSO for having organised this successful conference and I hope many of the issues raised today will be taken into account and based on many other forums in the future
(A participant from the service providers)

We are not raised actually to contribute to the community. Meaning of community and giving back to the community is alien to us. Even if you develop that sense and try to help young people, their parents and others may say to you, what is your interest? They are not your children
(A young man participant)

School dropout, gangs and radicalisation are [all] signs of mental illness caused by many factors including family condition, racism and so on
(A social worker participant)

Mental health is a common problems for those of refugee backgrounds who witnessed wars, experienced sudden loss of loved ones through wars, bombing, and endured difficult journey to be resettled to the West. These painful experiences can trigger at anytime to lead to mental problems
(A participant from NHS)

Fig. 5: An image captured by CSO at end of the mental health conference 27/03/2017

(Source: CSO).

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