Health in the Somali Community (Hounslow)

Accredited Community Research Course
2012-2013

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Acknowledgements

This is to say thank you to the Evelyn Oldfield Unit, the Refugee Council (for campaigning training), Hounslow City Council and the NHS (for previous research training), and the research participants. Also to Ilays and to the Somali community and finally, for those at Somali Home Cable TV helped us by their help publishing the results on the channel.
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Chapter 1: Introduction

This study is based on the Somali community living in Hounslow. The reason the research has been based in this borough, is that I have been working in Hounslow. Additionally, there is a large number of Somalis who reside in this borough. Having worked and seen many people affected by mental health issues provided me with the motivation to do this research.

In this research I will be focusing on analysing and discussing the causes of mental health problems among Somalis in Hounslow and in the UK in general, looking at how mental health affects individuals and families. The research will also attempt to understand the services that are available to patients. This will be done by examining secondary research. Primary research was also done in the form of interviews/questionnaires all of which backed up and supported by empirical evidence related to the issues around mental health problems for Somalis in the UK.

There is a lack of accurate statistics specifically on the number of Somalis with Mental Health problems, due to the fact that the NHS broadly categorises ethnicities and all the Somalis tick black British on standard pre-printed forms used by the NHS, this makes it extremely difficult to get an accurate number of those patients that are Somalis (Reynolds, 2012).

Researcher's Position

I am a community worker who was born in Somali but immigrated to Canada prior to civil war in 1987 and have been living in the UK over the past 5 years. I have many years of experience working and dealing with people that are affected by mental health problems. I am a health trainer and campaigner and this is why I have conducted this research. I have worked with ILAYS community organisation based in Hounslow and number 10 Mental Health Centre. This experience has made me familiar with many community members through my work, which in turn placed me in a better position to be able to earn the trust of the research participants.
Literature review

The civil war in 1991 lead to large numbers of refugees immigrating to the UK. Most of the Somali refugees arrived in the UK after the collapse of the Somali central government in 1991. The Conflict lasted more than two decades. The violence, destruction, death, misery, destitution and traumatic situations, that the majority of refugees who fled Somalia. It is more than likely to have witnessed and experienced horrific episodes which contributed to some of the immigrants in the UK having health problems.

The majority of Somalis living in the United Kingdom have immigrated as a result of a violent and deadly civil war, after almost two decades the conflict is still not over. Many of those who fled to the UK are now settled here permanently. However, the traumas associated with civil war, such as losing family members, witnessing death and destruction, losing one’s livelihood, wealth and starting all over again in an a new country as a refugees have affected their mental health.

Due to witnessing horrific events such as death and destruction caused by the conflict, a study by MIND (2012) highlighted that the most common mental health problems experienced by Somalis are post-traumatic stress, depression. This coupled with anxiety over their immigration status, lack of housing and language barriers among many other problems they experience.

There are many Somali women that suffer mental health problems. Somali women suffer mental illness as a consequence of family breakdown which leaves women to care for and bring up many children alone, lack of a support in the form of the traditional extended family which they were used to back in Somalia. Whereas the extended family support network offered to them support, guidance and advice on bringing up their children, family breakdown and all the ills that accompany family life, such as poverty. The absence of which has trapped them in isolation, fear and social exclusion. Somali women never speak up about illness in fear of stigma and losing their children to the authorities, which result in many women never speaking about their problems. A study by Obsiye & Salah (2012) noted that to some Somali women seeking support for mental illness is seen more than a taboo - it is an indication that they are not fit parents and are not able to adequately deal with the responsibilities being a parent brings.
The other major obstacle to Somalis seeking help is the fact that they hold a mistaken belief, that mental illnesses are caused by Jinn, a supernatural creatures and witch crafts. They therefore resort to traditional healers, as they don't believe that they can be cured by traditional medicine and scientific methods. (Mohamed 2012) This makes the prospect of getting medical help on time difficult and perhaps is an area for policy makers and service providers to look at.

According to study in 2002 (Gabriel, John; Ritchie, Helen, 2002) there are sets of identified social factors that impact the mental health of the Somali community. These include: social exclusion, including language barriers, poverty, housing, unemployment, immigration and racism; and cultural difference, including attitudes to mental health, khat and the effects of civil war.

Mental health problems are more prevalent among Somalis. The key factors that contribute to these are: being homeless, asylum seekers under immigration control, events such as family loss and family breakdown, poor health and the Khat (Obsiye & Salah (2012))

Traditionally Somalis who suffer from this illness usually go through tremendous efforts to hide their illness from others outside the family in fear of being stigmatised or excluded from the wider Somali society. It is the norm for the Somali community to stigmatise people with mental health or not visit their homes in fear of their safety (Gure 2012). This culture puts off many sick people from seeking help, which negatively affects any recovery prospect.

The concept of stress or other mental health related issues are not recognised in the Somali culture. The situation only captures the attention of family members or relatives with mental health when the individual is seriously ill and acts either violently or bizarre (Gure et al, 2012). Many members of the community are still unaware about various forms of mental illness because it is a social taboo and they believe it is a disease that can never be cured, that can bring shame on the family and bring disrepute to the honour of the family. Consequently, Somalis living in the UK despite the widely available support and medical treatment, they still dread to seek help. Relatives within the household also try to cover up and hide the individual's illness from other members of family and society in general. This view is supported in a recent report by Raynold (2012) which noted that even here in the
UK where medication and treatment is free, it is rare to see Somalis seeking the support they are entitled to.
Methodology

This section discussed the method I used to create interview transcripts which informed my data analysis.

This research used a qualitative research, Bryman (2001) defines qualitative research, as “a research strategy that usually emphasis words rather than quantification in the collection and analysis of data….it is inductivist, constructionist and interpretivist” (p. 264). An important thought, which informed the choice of qualitative methodology, is the need to gain an in-depth picture of the perceptions and experiences of people who suffer from mental health and those who do not suffer from the illness. This means conducting face to face interviews.

Another consideration for my choice of research method stemmed from the lack of adequate research into the Somali mental health issues, particularly the lack of confidence of individuals affected by mental health and their ability to seek help. This is sensitive to context and reflects insider’s accounts or participant experience of mental health issues.

Data Collection

In qualitative research of this nature, the question of access was central, since the wealth of the data to be collected ultimately depended upon my research participants. Additionally, people who granted interviews needed to be convinced that the research was of some value to them and be given assurances of the researcher’s integrity, so that they offer a spirit of co-operation during the interviews.

I did most of the data collection between December 2012 to February 2013. My objective was to conduct interviews with 10 people who have experience of mental health either directly or indirectly. This meant I had to handout 10 questionnaires to the participants, most of whom were aged between 25- 50 years and living in the London borough of Hounslow.

6 of the interviews were conducted at my workplace while 4 were conducted at participants’ locations.
In terms of research methods used and collated data, what really worked well for me was the opportunity to conduct face-to-face, one to one interviews with research participants. The advantage of conducting these face-to-face interviews is that I could clarify doubt and ensure questions are properly understood. I was also able to pick up nonverbal cues from the respondents. Any discomfort, stress and problems that the respondents experienced could be detected and accounted for, accordingly. The face to face interviews also gave me a real sense of my research participant’s personal experiences.

Secondary Data

Documentary sources were an important focus of this study. Yin (1994) points out that, “documentary information is of importance to every study topic and therefore should be the object of an explicit data collection plan. Furthermore, it can serve to corroborate or augment evidence from other sources.” Documents that were used were articles, reports and policy documents which reflect the incorporation of mental health issues of Somalis.

Sample Size

I handed out 10 questionnaires to research participants. (7) were male and 3 were female. All of them were originally from Somalia but immigrated to the UK over the past 25 years and were aged between 25 to 50 years.

The questions that were asked in the questionnaires were all aimed to cover the main themes, which were:

1. Mental Health: do you consider mental health to be an issue for the young people in the Somali Community?
2. What could be done to better support those with mental health in your community?
3. How could we support their families / community?
4. Have you concerns about drug or khat use in your community?
Ethical concerns

I assessed my role and duties as a researcher.

In order to protect the identity of my interviewees and in the interest of privacy and data protection, I have made them anonymous and did not disclose their names or any other information that can identify them.

Confidentiality, anonymity, fair representation were the main ethical issues considered in conducting this research. Researcher's positioning and the impact that it had on the creditability and validity of the research needed careful consideration, as some of the research was done at my workplace.

I guaranteed confidentiality and anonymity to participants reassuring that name and reference to any individual was removed from the findings and how research findings will be disseminated, was clarified. I explained all the participants about the purpose of the research and answered any questions that participants may have had. I did mention that participants have the right to not answer any questions that they don't feel confident and that they also have the right to end the interview at any point during the interview.

As a Somali male, who is a community worker, based in the same London borough of Hounslow as participants, my research could be seen as being biased. My identity was clear to my research participants, as most were known to me, either through work or through my other social networks. This meant they had the confidence and enthusiasm to share openly their experience and stories as the interview was being conducted.

All the participants were informed of the purpose of the research and voluntarily participated in the study. There was no incentive whatsoever for them in participating, so they all participated voluntarily and willingly.
Chapter 2: Research findings

1. Mental Health: do you consider mental health to be an issue for the young people in the Somali Community?

My findings show that mental health is a major issue for young people in the Somali community. Issues that contributed include the conflict that has forced them out of their country, consequently, had mental related illness including post-traumatic stress, anxiety and depression. The myriad of obstacles they encountered since their arrival in the United Kingdom has exacerbated their mental illness, include, language barrier, lack of housing.

The graph here below highlights various mental illness problems.

[Image: Graph showing various mental illness problems such as Trauma, Anxiety Disorders, Depression, and others with their respective percentages.]

[Link: www.cmha.ca/mental-health/understanding-mental-illness]
2. **What could be done to better support those with mental health in your community.**

The research found out that most would like to get access to an advice and practical support provided in their mother tongue.

There a significant phobia about coming out as mental health sufferer. Most research participants said that they are completely unaware what the consequences will be as a mental health sufferer, if they discussed with a GP or health official. Those with children were scared of the consequence and those that did not have children, where concerned that it will affect their future, for example, it may limit their access to employability, driving licence or in general negatively impact on their future. The research found out that the finding relevant information that is confidential from people they share similar language and culture would be good.

3. **How could we support their families / community?**

Around 40% of respondents would like their families supported through information. 60% said that it is difficult for their families to get support through relatives, as well through statutory agencies, as it takes long time to be diagnosed properly.

4. **Have you concerns about drug or khat use in your community.**

Almost 90% of people surveyed mentioned that Khat issue is affecting their life. About 90% of my respondents have mentioned that Khat use either affected their relationship or have caused family breakdown of their relatives. Respondents also mentioned their concern about the health and wellbeing of Khat users, as some users hardly can manage to either get meaningful employment or education.
Case studies

Mrs. X. is a 55 year old Somali mother who lived with her 29 year old son in London. The son became ill and the mother did not initially understand what was wrong with him but accused him of Jinni (Satan) possessions. "Jinni has been described as an entity that is living, but invisible to human beings, can assume various shapes, maintain culture and family and have capability to overpower the human brain" (Younis Y., 2000). The miss-diagnoses of his illness, lead to different manifestations related to mental illness and spent so much money on cultural based treatments. Since the situation did not improve, the mother turned to hospitals who prescribed anti-depressant tablets. The prescribed tablets, other than causing him to sleep too much, did not improve his situation. Thus, he started being angry at his mother and being very aggressive, since the mother did not get the appropriate treatment and support from the health professionals. She turned to report to the police her son's aggressiveness and behaviours. Again the police started to arrest him keeping him in custody for a day or so and then released him to attack his mother. The son eventually got so aggressive at his mum that he stabbed her to death. Only then, did the police and the health authority realise the severity of his mental illness, that they arrested him. He is at present in a secure psychiatric hospital where his situation is being assessed.

Reference: Ilays case study 2012

I have been a long time sufferer of depression. Every time I think I've escaped it with a day or two of relatively brighter moods, weeks and months of sadness, anger and anxiety follow. This negative extreme has been growing in particular over the past couple of years.

I currently live away from my wife and children. They’re in Canada, whereas I’m in the United Kingdom studying for a university degree. Our marriage last August was not under ideal circumstances. I had to marry in secrecy away from my blood family. (they live in the UK as well) They saw my girlfriend at the time as unsuitable and shunned any opportunity throughout our relationship to talk to her. I’ve always been the less favourite child. Having a younger, difficult to deal with sister, it was natural that my parents would cater to her requests more. So I was always one to hide in the background and not get overly involved. To compound matters, for 5 months of each
academic year I have to live with them in order to fund completing the degree. As can be assumed, the relationship there is incredibly unhealthy.

As much as I love my wife, when it comes these issues they’re ones I’ve had to face mostly alone. She doesn’t have the mental composure to help deal with the problems (she has diagnosed ADHD bi-polar as well as many other things). I could not talk with my friends about these issues because she has banned me from discussing it. I understand that she’ll feel insecure when I could be talking about her to friends of mine, but it’s resulted in me having no one to talk to and becoming more and more introverted and reluctant to go out and socialise.

Major financial issues, fighting with both my blood family and family overseas from the stress, feeling completely inadequate in my studies and physically (I am currently in the process of losing weight) and feeling completely isolated from everyone and anyone that could possibly help me, I have no idea what to do. I can’t even begin to understand myself with regards to which of those above reasons have been causing the depression and I have to start dealing with it somehow before it all gets out of hand. In different guises, I’ve had all the above issues in the time I’ve realised I’ve had depression. It’s crippling my relationship with both my wife to the point where at times I feel I just want it all gone to be left alone. My dreams have been getting progressively dark. I’ve always had the common “falling” dream but over recent years many dreams where I die from a whole host of reasons have become prominent and over the past few months I’ve been having dreams about having an affair.

It’s all a mental mess and I simply don’t understand what I can do to dig myself out of this pit. I don’t even know what I want because I don’t feel like I have any way of determining which of the many issues prompted this downward spiral. What can you possibly do in what feels like a permanent checkmate?

**Previous lllays research participant, 2013**

I hate everything about my life. My job, my husband, my house nad myself. I have tried for years to do things properly. I have worked hard and tried so hard to make things better. I am trapped in a life that I hate. I can never escape. No one can help me! I brought it on myself so that’s why I hate myself. Nothing has ever gone right for me and it never will. I am too much of a coward to kill myself but this would likely free everyone else as we’ll as me.
How could I have been so selfish to have had children? I am the kind of person I hate. I challenge anyone to find me a way out. It can't be done.

Ilays research participant, 2013

My name is F Hussein and this is my story. I am a young mum and at the time I was 22 years old when I had a very bad experience when I was in labour with my child, due to the care I was given by the midwives who were there at the time.

I had to go to hospital due to the pain I was having. The pain was getting worse by the minute but when I arrived at the hospital, I was told to sit down in the waiting area for at least an hour. By the time the midwife called my name I couldn't move, she said to me and my husband 'oooh! stop pretending you are just fine, every mum goes through the same things grow up and hurry up I have other patient to see', I was in so much pain I didn't reply, it was about 2.00pm.

I went in and as she examined me, she said I was almost 7 centimetres and the baby is about to come out, so they rushed me to the labour ward. In the labour ward I had 2 female doctors, they didn't like the heart beat of the baby because it was high. They also said that as my temperature was high, they will put me on drips. After a while, the baby’s heart beat became normal and my temperature got better as well.

The midwives changed shifts and I had new midwife after 3 hours. I was supposed to be examined again but was told by the new midwife that they have to take me to the theatre. I asked her why they were taking me to the theatre and she said because I am not progressing and they don't want the baby to get stressed. Therefore, it's better to do C section. I did not want to have a C section and she called another doctor.

The worst part was that nobody was giving me the correct information. The doctor said I was at risk of losing my baby. The baby will be still born and they will remove my womb and I won't be able to have any more children in the future. I rejected all this and followed my heart.

All this time, the pain was getting worse, they could see that but they ignored me and refused to check how far I was. After 20 minutes or so, the doctor was telling me how dangerous it was and how I will die. He left the room and as soon as he left the room, boooom! I screamed and the baby's head was out! Nothing was ready, the baby cloth, bed, temperature equipment, I continued to push and the baby came out flying, it nearly crashed on my
husband and he caught him. They all panicked, doctors rushed in, some came to my head side and some to my feet side. It was all chaos, they congratulated me and my husband.

Up to this date I am so scared of getting pregnant again and what it going to happen to me in the future if the care of the NHS Maternity is like this.

Somalian

Previous llays research participant, 2011

Another severe incident of mental health took place on June the 15th in a Birmingham mosque where a young Somali man attacked the imam and 3 of the congregation and a policeman. They are investigating what caused this now but it is clearly a severe mental health issue

Chapter 3: Discussion

The causes include:

**Witnessing war / violence / collapsed state**

Somalis have witnessed fighting for over 20 years in Somalia, including suicide bombers in Mogadishu. Somaliland is also affected by war. This creates trauma and shock. There is very little support (doctors). Most homes have someone in chains. This gives rise to such high incidences of mental health.

Somali TV (watched in the UK) shows very graphic detail of bombings and violence. There are 6 Somali TV channels, widely watched.

**Fear of Government intervention**

There is a lack of access – those with mental health problems stay away. They are scared by any government intervention. They are afraid of the stigma. Removal of children is a considerable fear.

**Lack of support available**

The respondents felt that it was difficult to access suitable support.

Not accessing available counselling – this is not something that was available in Somali. People prefer religion to lead their lives.

**Khat/ addictions**

Khat is highly addictive and also results in lack of sleep which makes any underlying issues worse. Khat also makes some people aggressive. Users lose sight of the moment and can do such things as spend the family budget. It causes family tensions. It also has physical effects such as dental problems and causes loss of appetite. This affects women too.
Shisha smoking often goes hand in hand and can make the situation worse (health wise but also the impact of the Khat is much stronger).

**Family break up / problems**

When Somali women arrive, family structures change. Women become less reliant on men. Some have had to marry through clanship or arranged marriage but on arrival in the UK, they choose to leave their husbands.

Khat addiction can also mean that the children are not brought to school on time. It tends to be taken at night, meaning that children are affected.

If a woman gets depressions, they often put on weight making them less happy.

**Not having enough money or understanding the UK systems**

Those newer to the country often don’t understand their bills, which can mean they are fined or have to pay interest. This can spiral out of control resulting in anxiety.

**Belief in supernatural**

Some believe in jinn and this is what causes mental health issues. Sometimes this involves hearing voices.

**The Solution/ Recommendations**

- Based on the results of this research, it is clear that there needs to be more community-based support for those affected by mental health, especially women.
- Centres such as the one Ilays runs offer a safe space where there is trust. Speaking their own language is essential to create this trust and understanding.
- The approach taken by Ilays includes emotional support – listening to worries, stories
- Individual motivational interviews/ coaching
The space allows socialising for isolated people.

We intend to offer a space for psychotherapists to come, they will be more likely to take part in any therapies if recommended by Ilays.

NHS intervention is effective, particularly when the intervention happens before the situation worsens. However, sometimes the patients are afraid to take their medicine but agencies such as Ilays can help the patient to understand the importance of this.

There also needs to be budgets for community-based support

There needs to be intervention and awareness-raising through mosques to reach out to more of the community

GPs need to make referrals to such projects

There needs to be more targeted counselling

There need to be trained Somalis in counselling

More schemes where there is suitable volunteering for those with mental health problems (such as our cooking project where those with depression were supported to cook food for homeless people at Christmas, with food donated by local shops and by the No 10 Project Hounslow).

The Council needs Somali representation

There needs to be an education programme regarding those who believe in jinn. They need to understand that modern medicines and treatments and doctors can be very helpful.

There also needs to be significant changes in Somalia and Somaliland. There are no hospitals, limited medication and people have to travel out of the country to access care. The mosque may offer some care but there is very limited support. It is essential to invest in Somalian mental health care.
Chapter 4: Conclusions

From this research it is clear that there is much to be done.

In the Somali community it is 1 in 3 who have mental health problems – it is a massive issue in our community. There are many causes and effects as listed above including trauma, family break ups, unemployment, depression and also khat use.

Although the recent census allowed for country of birth, but many people said Africa – there is still not a clear idea of how many Somalians there are in the UK. What is clear is that there are more than 101,000 listed in the 2011 census. This monitoring needs to be improved.

People with mental health problems are stigmatised, discriminated against and socially isolated. They’re also subjected to degrading and dangerous practices, such as being restrained with chains (back in Somalis). Mental health isn't integrated into primary healthcare in Somalia.

We very regularly hear of suicide bombs and violence from back home – this traumatises the community back home and here.

There is much to be done by NHS, GP, community services and organisations and by the Somali community.

Awareness raising sessions about the mental health as well as therapy - counselling, sports etc can impact positively on life.

There is currently not enough support to tackle this issue. More needs to be done on preventative measures rather than just giving out medication when it becomes more a problem. It needs be diagnosed early.

In Somalia more needs to be done on primary health care and the provision of specialized mental health hospital.
The strengths and limitations of research

It was easy to engage participants as I am a community worker and work in a known and trusted venue. I also have experience of mental health support for over 20 years.

I also promoted the research through the community radio and through my links in Canada, other mental health centres, and in hospitals. I attended meetings where I further promoted the research (including to the Minister of Africa, Mark Simmonds – Foreign Office). They all wish copies of the report when it is done.

The timing was also sufficient for me (over 6 months) as a result of keeping a diary and designing a gannt chart in class. Please see the appendix.

The questionnaire and interviews were particularly strong tools. The participants were more comfortable to talk and I got lots of interesting points of view.

Data protection was central to this study.

The main difficulty was the lack of budget – those taking part in the research could not be paid (they asked but we could not offer). Some participants think we have a lot of money!

If I were to do this again, I would like to further explore the effects of benefit cuts on those with mental health issues. The people we work with feel very under pressure to find work but may not be mentally capable. Also, a number of support agencies have lost funding, including a local homelessness centre. It would be interesting to explore the effects of this on mental health in the area. I would use an interview in exactly the same way as it was one of the strongest tools.

I would change the questions slightly – I would make some of the questions less direct and seek more solutions of the participants.
There also needs to be more research in the Somali community. Some of the participants we spoke to had never been consulted before.
Bibliography


Available at : Hiiran Online

Census 2011, Population by Country of Birth and Nationality –

[online] accessed May 2013

Express and Star (2013) Stabbed mosque policeman tells of “commando knife” attack


Mohamed H (2012) Somali capital struggles to provide mental healthcare, available on: http://www.guardian.co.uk/global-development/2012/apr/05/fighting-mental-health-somalia

Obsiye & Salah (2012), The Somali Community Needs to Learn to Deal with the reality of Mental Illness.

Raynolds Sile, (2012), Article: Awareness-Raising, Mind. available at:

Somali mental health, Canadian Mental Health Association: www.cmha.ca/mental-health/understansding-mental-illness (accessed May 13)

Yin (1994) Case Study Research, Sage Publications
