Mental health in Somali community in Bristol.

This report is survey findings and case studies we conducted in March 2019 in Somali community.

Mohamed A Sayaqle, 2019.

BSYV & BSF

This report is joint product of

Bristol Somali Youth Voice and Bristol Somali Forum.

Contact Us:

Bristolsomaliyouthvoice@hotmail.com

Somaliforumbristol@gmail.com

Table of Contents.

Cover Page: Mental health and Somali community in Bristol.

Report is presenting findings of survey conducted in March 2019.

Acknowledgement.

This report is reflecting survey conducted by group of dedicated volunteers from Bristol Somali youth voice and Bristol Somali forum, who invested their time to collect this important information and present it as evidence-based result. Their time, patience and commitments are much appreciated, we also like to send our gratitude Natasha Carver, PHD candidate of University of Cardiff who also put indispensable effort both for the report and survey questionnaire.

The report is written by Mohamed A Sayaqle from Bristol Somali youth voice, it has been reviewed and edited by Natasha Carver PHD candidate of University of Cardiff and Abdul Ahmed Chair of Bristol Somali forum, the report presented here is reflecting survey conducted in Somali community in March 2019, all the respondents are from Somali background with different gender, age group and profession. the survey is reflecting the answers of the respondents from Somali background, to reflect why Somali community in Bristol aren't accessing available mental health services include primary mental health services and other organisations that support people with mental health issue.

Here is the list of the people who contributed conducting the survey and preparing this report, and we would like to recognise their patience and hard work, Mohamed A Sayaqle, Abdul Ahmed, Saed Burale and Natasha Carver.We also like to extend our gratitude to Nura Aabe from Autism independence and Monira Chowdhury from CASS Networker.

Introduction.

Black and minority ethnic (BME) communities continue to experience inequalities within the U.K. mental health system. Despite numerous policy documents and review that have been published or commissioned by UK government, to tackle down mental health inequality and to improve the poor outcome experienced by many service users still ethnic inequalities in mental health provision are issue and continue to be a cause for concern. This challenge is reflected in NHS England's Mental Health Taskforce Report and national 5 years plan for NHS mental health services to 2020-2021.

Th e U.K. policy initiative "Delivering Race Equality in Mental Health Care" (DRE; Department of Health, 2005) promised an ambitious strategy to address mental health inequities. Despite the government's positive review at the conclusion of the program (Department of Health, 2010a), evidence presented from the final annual national census of inpatients in England and Wales painted a different picture.

The Count Me In census sponsored by the Department of Health suggested that the policy directive had very little impact on narrowing the health gap at the national and local level (Care Quality Commission, 2011).

Various evidence shows that many BME groups experience significant variation when accessing mental health care pathways in Bristol and across the country specially target group in this survey which is the Somali community in Bristol.This shows that some BME groups are less likely to enter and be referred to mental health services through their general practitioner and more likely to be arrested by the police following a crisis, which inevitably results in poorer health outcomes and often-coercive forms of care in locked wards.

A report from the independent Mental Health Taskforce to the NHS in England February 2016, indicated that Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. The rise is most marked amongst middle aged men. The Somali community in Bristol have seen patterns of death and suicidal cases caused by mental health problems over the past 5 years.

In comparison to White people, more BME people are diagnosed with mental health issues every year. BME communities are also facing barriers in terms of accessing culturally appropriate services, including lack of cultural understanding, communication issues, and where and how to seek help. Service providers need to work closely with people from BME communities prior to service design and delivery. Information should be made available in appropriate languages to support understanding about their illnesses and how they can seek help. Frequent reviews may further help assess BME communities' needs and make required changes and implementations.

Different Researches shows that BME communities accessing mental health care services do not always experience the quality of care to which they are entitled

(Department of Health, 2003,2005; Fernando, 2010; Sewell, 2012). Evidence of inequality in mental health outcomes is well documented and referred to frequently in policy documents and reviews (Johnson et al., 2004). Ethnic inequalities have been highlighted as a cause for concern within many government policies, including the National Service Framework for Mental Health (Department of Health, 1999), “Inside Outside” (Department of Health, 2003), and the DR (Department of Health, 2005).The same challenges has been highlighted by a report from the independent Mental Health Task force to the NHS in England February 2016.

Research conducted by Mind (2011) details comparisons across ethnic groups regarding mild, moderate, and severe mental ill health. It shows that women from Black groups experience higher than- average rates of detention within mental health services, and, as a whole, the Black community is less likely to be diagnosed with mild to moderate mental health conditions, such as depression and anxiety, relative to their White counterparts.

Similar to this, In our health well-being project with Oisis Talk, 80% of the beneficiarys admitted they don’t report stress, depression or anxiety. After delivering this project through community-based sessions, we have recorded most the of the beneficiers had either sleeping problems, stress, anxiety or post traumatic depression, but were hesitant to use available mental health services. Somali woman are more likely to have stress, depression then men but don’t seek help due to stereotype, social workers may involve and concern their parental responsibility which might lead to lose their children and social workers take away.As findings from both the survey and our caseload records shows that these are key determinants influencing and exacerbating their vulnerability of mental health problems.

Aims of the report.

Mental health has been issue for Somali community in Bristol, After several death and suicidal cases recently in the community, there were growing concerns about why community aren't accessing to primary mental health service?

This report aims to provide insight about mental health problems in Somali community and the multiple barriers that community face to get access to available services, and how to improve mental health inequality and current delivery method(s) for disengaged communities. It is hoped the report would help to identify the loopholes and foster relationship between the BME community and mental health service providers.

Background.

Mental health in Somali community in Bristol.

Mental health has been an issue for ethnic minority community in Bristol, specially Somalis, the largest ethnic minority community in Bristol. Cultural stereotype and stigmatization has prevented community members to use and access available services, there are clear reasons on why BAME people are overrepresented on secondary mental health services. After several death and suicidal cases in Somali community, mental health problem has become an issue and growing concern for the community. Community members from Somali background are not connected and not using primary mental health services include GP and other main stream organizations. We have also seen pattern of death and suicides of the people with mental health problems. Bristol Somali forum and it's co-organizations, have noticed and been involved with a number of mental health cases at crisis point through police and justice system.

In March 2019, Bristol Somali Forum and along with Bristol Somali Youth Voice had conducted a mental health survey in Somali community. The survey's aim to provide insight about mental health problems in Somali community and the multiple barriers that community face to get access to available services, and how to improve mental health inequality and current delivery method(s) for disengaged communities.

Themes Analysis.

A. Discussion.

The Somali community is largest ethnic minority community in Bristol, this report is part of a survey we conducted recently about mental health and the Somali community in Bristol. The survey was conducted March 2019.There were 50 people from Somali background, respondents are from different age, gender, profession and experience, include students, parents , old people, working people, domestic violence victims, friends and family who are connected to someone who suffered mental health problems. The survey was conducted face-to-face. All the 50 respondents are reside and live in Bristol.

Most of the respondents have indicated perception of ethnic inequality in mental health system, the importance of culturally appropriate services and practical delivery methods which can work all the community include ethnic minority communities include active engagement and effective awareness program at grass root level.

Table below (Table 1) shows mental health questionnaire findings to give clear map of respondent's answers.

Descriptions	Available Numbers	Percentage
Have you ever have stress, depression or other mental health problems.	YES: NO:	42% 58%
Have you ever contacted the GP or health service about a mental health problem either for yourself or someone else?	YES: NO:	17.24% 82.76%
Are you more worried about mental health among:	-young people -middle-aged people -old people	48.28% 44.83% 6.9%
If you, or someone you know, had a mental health problem, how likely are you to seek help from the GP or another mainstream organizations?	-Very likely -Likely -Unlikely -Very unlikely	27.59% 27.59% 10.34% 24.14% 10.34%
What stops you getting mental	-Lack of time	0%

health services	-Stigma and cultural stereotype -Lack of information -Lack of knowledge -Communication problems -I prefer to use alternative resources -Other	31.03 % 13.79 % 6.9% 3.45% 37.93%
Do you know someone, who you think has mental health problems and needs support?	YES: NO:	44.83% 55.17 %
How confident would you be about recognizing the signs and symptoms if a close family member was suffering from a mental health problem?	-Extremely confident -Very confident -Somewhat confident - Not so confident -Not all confident	6.9% 34.48% 41.38% 13.79% 3.45%
Have you heard of CAMHS (Child and Adolescent Mental Health Services)?	YES: NO:	10.34% 89.66%
Have you heard of the organization 'Off the Record'?	YES: NO:	10.34% 89.66%
Do you think current delivery method is working for Somali community?	YES: NO: NOT SURE:	10.34% 62.07% 27.59%

Do you think, partnership work between grass root organizations and mental health services can help to overcome stigma of mental health problems and accessing available services?	YES: NO:	82% 18%

Table 1: this table give information about answers of the respondents on the survey, and numbers are presented as percentage.

Mental health questionnaire findings (Table 1, page 10,11,12), 42% of the respondents had admitted they had Stress, Depression or anxiety in the past, however,82.76% of the respondents said they are less likely to contact or recommend someone to mental health services, but still large number of the respondents commented that police and mental health services can improve the service through working with grass root organizations and up skilling health care workers to improve their cultural competences.

41.8% of respondents said , they are confident to recognize signs and symptoms if friend or close family member is suffering mental health problem but unfortunately 82.7 % of respondents admitted they would not contact GP,here is the problem we all need to navigate why community are hesitant to use the service.

In this survey, 48.28% of the respondents worry about mental health of young people where 44.83 worry about middle age.All recent cases are consistent with respondents answers, where victims were all younger than 60, where quarter of them fall below 30.

This report focuses to navigate and explore barriers of mental health services experienced by Somali community in Bristol, patterns of recent death and suicidal cases in Somali community, and how to improve and connect community to available services, the result show Somali community are not accessible to available mental health services.

Respondents have indicated cultural stereotype, stigmatization and lack of practical delivery method and appropriate engagement has caused to prevent community to use available mental health services.

Lack of proper accessing of mental health services is reported across community, for example , in partisanship with Oasis talk , we have delivered health well-being, through community based sessions, this program has implied the need for different delivery methods, by Reaching out to elders (community)at their comfort zone, in these program we have recorded number of service users, who need help and hasn't contacted to mental health services, after building trust and relationship with service users, the well-

being session empowered understanding about mental health problems and this has caused to refer 20% of the service users to special services.

Only 25% of respondents said, they neither have mental health problem nor family or friend who experience mental health problems.

For many social and cultural reasons ethnic minority communities specially Somalis tend to function to a large extent, they are interconnected community, where extended family are quite coherent and help full specially when someone face challenges like mental health problem however, there are cultural and social stereotype which shape challenges that person with mental health problems face, which impact accessing to mental health services, interaction with the community, recovery pathway and person's life. ***Mental health is wide spectrum from simple, mild to serious mental health. Like other ethnic minority communities, Somalis are less likely to report and seek help at early stage in comparison to their white counterparts.***

The findings of this Questionnaire indicate an urgent need for more work to address the stigma and cultural stereotype around mental ill health. Worryingly 44.83% of respondents have said they are dissatisfied with current delivery of mental health services and big number proportionally responded they will not recommend someone to mental health service both primary and secondary.

The survey results show that the lack of appropriate awareness program and practical grass root delivery method are essential to address and overcome stigmatization and cultural stereotype in disengaged communities; to help people to speak out and being able to speak up for themselves, it is important for everyone to boost their confidence, self-esteem and mental well-being. The survey asked the extent to which people satisfied or dissatisfied to available mental services, after number of death and suicidal cases in Somali community, large part of the community aren't confident that current delivery methods can work across all communities, but still haven't lost the trust and believe police and mental health service can improve their service to all necessary measures and intervention to improve the services.

B. Underlying causal issues of mental health problems in Somali community in Bristol.

The scale of the ethnic inequalities of mental health system is largely known, and patterns of death and suicidal case in Somali community in Bristol is alarming concern for the community, which is also clear indication that system is not working as it should be. The root cause of growing concern of mental health is complex, no single explanation can be reliably applied to suggest solution but understanding ethnic inequality in mental health is an important to compile effective and

practical solution.

Th e science of problem solving in organizations focuses significant attention on understanding root causes of problems (see Bicheno & Holweg, 2009). Health and social care systems that wish to correct patterns of poorer outcomes for BME groups will need to have a good understanding of why the care and treatment they provide has less impact on these groups.

I. Lack of practical delivery plan at grass root level.

There are various evidence that indicate public engagement of mental health services include GP and mainstream organizations in Bristol are not practically working specially for target group 44.83% of the respondents indicated they are dissatisfied with current mental health services, and they are unlikely to recommend someone to the services. Although stigma and cultural stereotype are factors in this assumptions, our caseload record of well-being project with Oisis Talk, shows most of the beneficiaries are not connected to primary mental health services. Similar to this, 89.66% of respondents in the survey has said they haven't heard about CAMPS and Off The Record, which are based an area where large number of Somalis are living.

II. Communication barrier.

Effective awareness and active engagement are key to address mental health problem in ethnic minority community in Bristol, especially Somalis, who recently have seen 8 cases of death and suicide for past 8 years. However, in the United Kingdom, many BAME communities do not speak English as their first language. As diagnosis is contingent in large part on individuals being able to explain and articulate their experiences, this may have a bearing on the outcome of any such diagnosis (Fountain & Hicks, 2010).

Lack of proficiency with the English language is one of the main barriers to accessing mental health services for many BME service users. Satisfaction with mental health services is higher where service users and service providers speak the same first language (Fountain & Hicks, 2010).

III. Western model of psychiatry

Mental health and illness are taboo for some communities and very complex to deal with. In Somali context talking about mental health is like talking about madness and craziness, and there fore seeking professional help could be perceived as being embarrassing. Also mental health services in United Kingdom operate with in Eurocentric paradigm, which might influence the way people from BAME communities are diagnosed Fernando (2003).

Cultural competence among the staff working with BAME service users are important to enable health professionals to examine their own worldview and that of the patient to combat unconscious and implicit bias, particularly in the assessment of mental health illness.

Perception of illness and disease and their cause are different in various cultures, and culture also influences how people seek health care, and how they behave towards health care providers.

Stigma and cultural stereotype prevent ethnic minority community specially Somalis to welcome early intervention and accessing mental health services until crisis point. seeking professional help could be perceived as being embarrassing.

IV. **Racial disadvantage and discrimination**.

The patterns of death of suicidal cases in Somali community (8 death) in Bristol has raised concern about the police and mental health services, all the people who died and involved in these cases were familiar to police and mental health service providers, some of the them had been on medications, and had mental health navigators.

BME males are less likely to self-identify that they have a mental health issue; they also have less awareness of the services that are available to help with such issues (Men's Health Forum, 2006). There may be a variety of reasons for these facts, including fear of consequences of reporting a mental health problem (White, 2006). These issues are compounded for African and Caribbean men (Keating & Robertson, 2004).

The respondents in the survey have highlighted the system is not fit for purpose, and not working with BAME community specially Somalis in Bristol, they argue this continuous death and suicidal cases should bring review of the system and available services.

V. Social model of health.

The significance of addressing the wider determinants that affect physical and mental well-being has been recognized by the Department of Health (2011) in its policy, No Health Without Mental Health. Socio-economic factors are key determinants of mental well-being (Wilkinson & Pickett, 2010), and the income equality gap between BAME communities and their White counterparts is widening (Office of National Statistics,2010) with BME communities experiencing significant inequalities in different aspect of the life.

Lack of the representations in senior management levels and involving designing of mental health policy are also key factors to compile effective and practical change, most of the respondents in the survey has indicated, partnership work between mainstream institutions and grass root organizations led by BAME community members could make difference for connecting disengaged group to available services and to empower community members to overcome stigma and cultural stereotype to use the mental health services.

There are several examples of social inequalities and vulnerability to mental ill health by sections of the BME community. For example, Keating (2007) found that Black men are more likely to be excluded from school, experience economic and social hardship, experience greater exposure to criminal cultures, and be the subjects of racial abuse.

Also, the support and recognition of physical, psychological, and health needs of asylum seekers are significant, as many are arriving from countries with high prevalence of infectious diseases or torture, which can be exacerbated further by poor living conditions once they arrive in England (Keating, 2007).

Recommendations.

A. Survey findings and issue identified by the report doesn't mean, mental health is issue only for Somali community, there are there so different researches and case studies referred in this report which clearly show that mental health inequality is and has been issue for ethnic minority communities.

B. There are number of mainstream organisations that work at inner city, specially the wards that largest Somali community are living, unfortunately, the report findings have identified that these organisations are not reaching out in the community, For example, two organisations, we asked the respondents in the survey, CAMHS (Child adolescence mental health service) and OFF THE RECORD are based in Lawrence hill and St Puals, an area that largest Somali community are living, but unfortunately almost 90% of the respondents said they

never heard. As such there should be reviews and assessments to ensure the services are working for all communities.

C. Stigma and cultural stereotype are main barriers of accessing *mental health services, especially primary mental health services but also survey findings identified, lack of culturally appropriate service and lack of cultural competence in mental health service care professionals are also issue. Improving Cultural competence among the staff working with BAME service users are important to enable health professionals to examine their own worldview and that of the patient to combat unconscious and implicit bias, particularly in the assessment of mental health illness*

D. There are cultural and social stereotype which shape challenges that person with mental health problems face, which impact accessing to mental health services, interaction with the community, recovery pathway and person's life. As such the report suggest service providers should imply different strategy and use community-based assets, work with community at grass root levels through active awareness and engagement. Developing engagement and inclusion officers and allocating resource for reaching out disengaged groups would be helpful.

E. Lack of inclusion and representation at decision making level is/has been issue, this is also true in Somali community, there are no enough number of Somali professionals at different levels in mental health institutions. Service providers need to work closely with people from BME communities specially target groups prior to service design and delivery.

F. Many BAME communities do not speak English as their first language. As diagnosis is contingent in large part on individuals being able to explain and articulate their experiences, Information should be made available in appropriate languages to support understanding about their illnesses and how they can seek help. Frequent reviews and assessing loopholes could help to compile a positive change.

G. The patterns of death of suicidal cases in Somali community in Bristol has created strong feeling and concern about the police and mental health service providers, Most of the people who died or involved in these cases were familiar to police and mental health service providers, some of the them had been on medications, and had mental health navigators. The respondents argue there are enough evidence to bring review of the system and available services.

H. Findings identify appropriate awareness program and practical grass root delivery methods are essential to address and overcome stigmatization and cultural stereotype in disengaged communities, to help people to speak out and being able to speak up for them selves, it is important for everyone to boost their confidence, self-esteem and mental well-being. As such this report recommend implying different strategy to compile different outcome. Working and

empowering community organisations at grass root levels are important, also improving equality and representation in terms of accessing resource can pursue positive change.

Conclusion.

- Mental health inequality has been issue for ethnic minority community include Somalis, there are no single explanation to apply why certain part of the community are not accessing to available mental health services, but there are/have been enough
- evidence to understand urgent change is needed.

- Perception of illness and disease and their cause are different in various cultures, and culture also influences how people seek health care, more BME people are diagnosed with mental health issues every year. BME communities are also facing barriers in
- terms of accessing culturally appropriate services, including lack of cultural understanding, communication issues, and where and how to seek help. Service providers need to work closely with people from BME communities prior to service design and delivery.

- The findings of this Questionnaire indicate an urgent need for more work to address the stigma and cultural stereotype around mental ill health.

- There are so good number of voluntary Somali led organisation that work at grass root levels, Service providers should work with these organisations to reach out the disengaged groups and improve their services.

Terminology and definitions.

Mental health problems- this term is frequently used in the report to refer wide range of mental health conditions/disorders that effect your mood thinking and behaviour, ranging from common problems like stress, depression and anxiety to rarer problems like schizophrenia and bipolar disorder.

Stigma: this is used to describe the shame and strong feeling of disapproval that most people in the community have about beingassociated with mental health issues, that is rooted cultural stereotype and mental health which precisely mean madness and craziness in Somali context.

Black Asian Minority Ethic (BAME): This is frequently used throughout the report and is referring to Somali ethnic group or members of other minority groups. The report based survey conducted in Somali community in Bristol, but it can also reflect to most other BAME community in Bristol.

Respondents: these are the people who involved the survey and gave answers of questionnaire survey, they all live and reside in Bristol, and they are from different

gender, age group and profession- survey tried to reach out people with different capacity to reflect good pattern in the community.

however, it could very easily apply to most other BME communities' experiences in Bristol. Causes: Factors identified to contribute to mental health issues/problems affecting the community.

Profession: any type of work that needs special training or particular skill, often the one that is respected because it involves high level of education. This was important to examine knowledge of the community in mental health mainstream organisations, for example, where 89.60% said, they don't know about CAMPS and OFF THE RECORD.

Young people: this is referring to children under the age of 18 years.

Bristol Somali Youth voice (BSYV): is organisation that advocate and empower disadvantaged young people in Bristol predominantly from ethnic minority communities include Somalis.

Bristol Somali Forum (BSF): is umbrella organisation that represent 19 Somali lead organisations in Bristol.

References:

Care Quality Commission. (2011). Count Me In 2010 census. Retrieved from http://www.cqc.org.uk /organisations-we-regulate/mental-health-services/count-me-2010-census

Department of Health. (2010a). Delivering race equality action plan: A fi ve year review. Retrieved from Journal of Psychological Issues in Organizational Culture, Volume 3, Number S1 • DOI: 10.1002/jpoc 155 http://www.nmhdu.org.uk/silo/files/race-equality - action-plan-a-fi ve-year-review.pdf.

Department of Health. (2011). No health without mental health: A cross-government mental health outcomes strategy for people of all ages. Retrieved from http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf.

Equality Act. (2010). Retrieved from http://www.legislation.gov.uk/ukpga/2010/15/contents.

Fernando, S. (2003). Cultural diversity, mental health and psychiatry: The struggle against racism. Hove, England: Brunner-Routledge.Fernando, S. (2010). Mental health, race and culture. London, England:Palgrave Macmillan.

Fountain, J., & Hicks, J. (2010). Delivering race equality in mental health care: Report on the fi ndings and outcomes of the community engagement programme 2005– 2008. Lancashire, England: ISCRI. Retrieved from http://www.uclan.ac.uk/schools/school_of_social _work/fi les/DRE_CE_full_report.pdf.

Mind. (2011). Mental health fact sheet. Retrieved from http://www.mentalhealthmatters.com/fact-sheets Mind. (2012). Statistics 3: Race, culture and mental health [Fact sheet]. Retrieved from http://www.mind 156 Journal of Psychological Issues in Organizational Culture, Volume 3, Number S1 • DOI: 10.1002/jpoc.org.uk/help/people_groups_and_communities/statistics_3_race_culture _and_mental_health.

White, A. (2006). Men and mental wellbeing—encouraging gender sensitivity. Mental Health Review, 11(4),3–6.

Wilkinson, R., & Pickett, K. (2010). Th e spirit level: Why equality is better for everyone. London, England: Penguin Books.