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## Acknowledgment

Many individuals have contributed to the success of this Project. It is the result of three months of hard work and dedication by various members of the Somali and the Mental Health service communities.

Our sincere appreciation is extended to members of the Steering Committee, the Reference Group and the people who participated in the focus group discussions. Our gratitude also goes to all those individuals who shared with us their experiences through interviews and who contributed with literature and other written information.

Finally, this project would have not been feasible without financial assistance from the Ontario Ministry of Health.

## I. BACKGROUND

During the course of the last few years, the occurrence of suicide and major mental health disorders within Toronto's Somali Community gave concern that mental illness was on the rise and was causing severe distress for families and individuals. Due to many of the problems suffered in the civil war in their homeland and difficulties encountered in settling in Canada, Somali immigrants were felt to be at high risk of developing emotional and psychological disturbances.

The mental health needs of ethnoracial groups are considered equal, if not greater than those of the 'mainstream' population. However, ethnoracial groups are disadvantaged in that they use less mental health services. Additionally, ethnoracial immigrants require specific programmes that properly address their mental health problems".

In order to examine the issue of the mental health needs of the Somali Community, a meeting between representatives of Community Health Centres and Somali community agencies was convened. The meeting took place at Rexdale Community Health Centre on March 5, 1998. Participants were of the opinion that mental health problems were causing distress in the community and unanimously agreed on the need to conduct a study for a more accurate assessment. A proposal for funding was initiated at the meeting and partnership established between York Community Services (YCS) and Rexdale Community Health Centre (RCHC). A Reference Group, composed of the two CHCs and Somali agencies that participated at the meeting was established. (See *Attachrrieia I*).

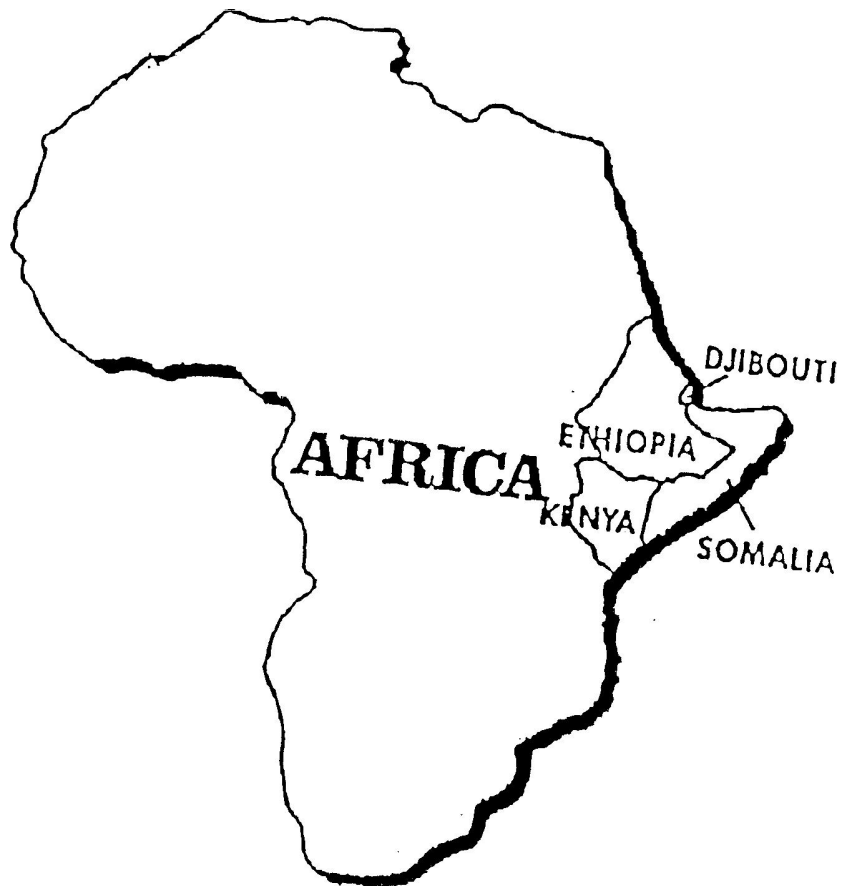
The objectives of the project were:

- a) To identify what was presently being done in the area of research into the Community's mental health needs
- b) To analyze and report on relevant reports related to mental health
- c) To report on the type of mental health problems affecting the Community, the difficulties experienced in service utilization, range of existing mental health services and programs and models for mental health promotion strategies
- d) To make recommendations respecting Toronto Community Health Centres preferred role and involvement in the area.

## 2. THE SOMALI COMMUNITY i)

### Arrival and Settlement in Canada

The Somali Community is one the newest communities to settle in Canada. Somalis come from the eastern African region known as the Horn of Africa. Somalia is a peninsula of 637,140 square kilometers (se the map below). The last official census taken in 1987 estimated the Somali population at 6,590,325. The people of Somalia are called Somalis (occasionally Somalians) and the official language is Somali.



Recent Somali history has been tragic. A military regime led by General Siad Barre took power in Somalia in October 1969 and ruled the country for 21 years. The difficult sociopolitical conditions created by the regime and repression against opponents forced many to flee the country. From the late 1970s through the 1980s armed groups fighting to oust the regime were founded. The struggle gained strength and culminated in January, 1991 with the

overthrow of the Barre regime. Unfortunately, the clan-based factions who succeeded Barre were unable to form a government of national unity. The country disintegrated into anarchy and civil war. Over one million Somalis fled the country seeking protection in countries around the world. Most ended up in refugee camps in neighboring countries but a significant portion were accepted as refugees in countries outside the region particularly in Europe, North America and Australia and New Zealand. Hundreds of thousands died as a consequence of the war. Today, Somalia is still without a recognized national government.

In Canada, the majority of Somali-Canadians arrived and settled during the last 10 years. Only a few hundred Somalis lived in Toronto in 1987; this number went up to 22,500 by June, 1991'. The peak influx of Somali refugees was reached in 1994-1995. Today, the size of the Somali Community in Toronto is estimated at between 50,000 and 70,000. Somalis live across the City of Toronto with high concentration in the community council districts of Etobicoke, York, Scarborough and Toronto.

Many Somali-Canadians have lived through horrible trauma, physical atrocity and seen the loss of loved ones in the civil war. Overnight, a great number lost whatever properties or wealth they had. Many spent prolonged periods of harsh life in refugee camps in Africa before coming to Canada.

Upon arrival in Canada, Somali refugees get a sense of relief for the end of their nightmare of persecution and torture. However, happiness is often short lived, because, in spite of the feeling of safety and the satisfaction of arriving in a country where they had their immediate needs met, they found themselves confronted with a host of cultural and other barriers. Uncertainty for their own future and concern for the safety and well-being of families back home, are continuing stressors for many of these new Canadians.

## ii) Religion

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

## iii) Family

Traditionally, families are headed by the father. In the family everyone has a specific role. Care of the children is primarily a responsibility of women though in practice everyone contributes to their care: parents, older siblings, other relatives, family friends, neighbours. Somalis love children with the dream of every couple to have several children. The fertility rate in Somalia was estimated at 6.76 children born/woman in 1997<sup>4</sup>. This is significantly higher than that of North American families. In Toronto, due to affordability and availability in size of accommodations, Somali families often live in overcrowded conditions'.

Seniors are highly respected, live with or are cared for by their offspring. Somalis keep in close contact with their extended families. Everyone is expected to support members of his/her kin, likewise everyone can expect support from relatives. Physical and sexual abuse of children is not known in Somali society.

#### iv) Health practices

The concepts of health and disease are based on a mixture of Muslim and traditional Somali beliefs. Overall, Somalis believe that illness and healing occur only by the will of God (Allah). This creates a particular attitude towards illness. Suffering from a disease is not seen as totally negative. It has a positive reverse to it: forgiveness of one's sins by God. Disease is accepted and the condition is to be borne with dignity. Complaining too much about ill health is seen as inappropriate and poor behaviour. All minor ailments are not perceived as illness. Culturally a person is either sick or in good health.

A sick person is never left alone. Hospital bedsides are often crowded by relatives, friends, neighbours and other well-wishers. In Somalia, doctors do not deal with the patient alone but with the family. The family is always part of all important decisions.

##### *1) Traditional medicine*

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

Though ultimately every illness occurs under God's will, some diseases are thought to be caused by other people or by spirits. Very common among interpersonal diseases is the so-called "il" (evil eye). A healthy or wealthy person may fall ill or have an accident because they were evil eyed by a less lucky person. Other causes of disease are curses. Curses by ill treated or disregarded parents are among the most dreadful ones'. Diseases can also be caused by witchcraft. A majority of Somalis also believe that some diseases are caused by spirits ("jinni" or "jin" .

The concept of communicable diseases is well understood and keeping of good hygiene is seen to be very important. The linkage between mosquito bites and malaria was well understood long before "modern" medicine discovered it'.

Traditional methods of treatment are still used by Somalis alongside conventional medicine. Most common among these are Quranic readings, use of a wide variety of herbs, cauterization (applying a thin burning stick or metal on the affected part), scarification, fumigation and wearing of amulets. Surveys carried out in Somalia in the 1980s show a widespread use of traditional medical practices'.

## 2) *Mental health*

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Traditional concepts hold that mental diseases are mainly caused by "jin". These may cause the affected person to see images or to hear voices, which are not perceived by others. Minor mental disorders are often not perceived as health problems. The individual and his/her relatives do not detect them promptly. Abnormal behaviour, unless impressive, is not taken seriously and is often ignored. Concepts of stress and depression are not recognized in the traditional health care system. All of this may result in care seeking starting later and at a more serious stage in the problem.

Normally a disease is accepted by the individual and the family as the will of God (Allah). This is very helpful as a way of coping with the illnesses' pain and distress with dignity and without having to recourse to desperate action. It is also an explanation as to why suicide is rare in Somalia. The main difference in people's behavior towards physical and mental disorders is that mental disorders carry stigma and therefore are not easily accepted or may even be denied. However, the stigma never leads to ill treatment or abandonment. Families support relatives through all imaginable hardships.

As for care, medical attention is not always the first to be solicited. One-to one counseling with mental health professionals is not a cultural norm and thus not much sought after. Normally, counseling is done within the family or with community elders. Individuals are treated with Quranic readings, administration of herbs, fumigations etc. In some cases the "devil" is driven out by exorcism in procedures somewhat similar to practices in other religions. Also non-religious rites are practiced to drive spirits out by means of dances, songs, perfumes and fumigations. Notorious among such rites are "mingis", "saar", "borane" and "hayat"<sup>7</sup>

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### v) *Difficulty of Life-in Canada*

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

#### *Language*

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

#### *Weather*

Many Somalis have great difficulty with Canadian weather. Coming from a dry and warm land on the equator, Somalis have difficulty adjusting to continuously changing weather conditions, the long cold winters, snow and rain. A significant number of people especially

seniors and mothers with small children, rarely venture outdoors during the winter months.

### *Family life*

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

During the civil war, many men were separated from their families; some were killed or imprisoned, others remained behind to defend their properties or for other reasons. A consequence of this has been that many Somali families in Canada are formed on the basis of single mothers with children.

Family life presents new challenges for all family members.

Alan previously were the breadwinners and had the leadership role in their families; they lost both roles. Unemployment, poverty and loss of status cause both stress and loss of self-esteem in a large number of Somali men. They feel powerless at home and outside in the community.

Women now carry two burdens, that of mother and of being breadwinner and leader of the family. At the same time they do not always enjoy the support of an extended family. Many have to play a new role, which they were not used to. Somali women experience a great deal of stress in raising and educating their children especially teenage boys. Single parent families are a rare exception in Somalia. Even when children live with one of the parents, there are relatives who support the family and contribute to their education.

*Children are* confused by the dual culture they live in at home and outside in their schools. This may cause behavioral problems and learning difficulties in some Somali children. Children are constrained in their activities by space limitations at home, weather and concerns about safety in the community. There is an inter-generational gap between children and parents with children adapting fast to mainstream Canadian culture with adults holding fast to their traditional one. The problems faced by the younger generation may cause loss of self-esteem. Some youth go to jail for petty crimes. Some of them are reported to be abused during detention and come out with mental health problems. The problem is made all the more serious by the lack of rehabilitation programs for such youth.

The phenomenon of the so-called hyperactive children is new to most Somalis. A frequent complaint is that Somali children are labeled with this term. The reason for this has not been explained or studied. This creates a significant community problem with the school system. There is a strong feeling that schools send too many Somali children for psychological assessment. Additionally, many are seen as failing the assessment as a result of it being based on concepts alien to Somali culture. There is also a perception that a great number of children

are ending up in special needs programs or ESL classes. This includes Canadian-born, English speaking children. Stereotyping and discrimination based on culture and race are seen as operating factors by the community.

There is widespread community frustration with the way that Canadian social, educational and judicial systems interact with the traditional Somali family, in terms of values and parental roles and responsibilities.

People would like to raise their children the way they were raised by their parents. However, this is seen as a dream for many. In discussions within the community it is common to hear comments such as "With all the talk about rights and freedoms, the Canadian system penalizes parents by suppressing their right to raise their children the way they feel is the best"; "there is no respect for new immigrants' culture and feelings. In order to align children with mainstream culture, the system is ready to alienate adult newcomers"; "it is too much change too fast"; "the worst thing that may happen to a father and mother is that the Government takes away their children and give them to others".

### *Employment*

The vast majority of Somalis have a hard time finding jobs in Canada. Unemployment and underemployment are among the top-ranking problems encountered by Somalis. Unemployment affects men and women, youth and adults, highly skilled professionals, trades people and unskilled individuals. A study carried out in 1998 by *Midaynta, Association of Somali Service Agencies*, identified the following as the main barriers facing Somali professionals and trades people: Lack of Canadian work experience, lack of information to available services, access barriers to educational upgrading and retraining, lack of centralized academic credential assessment services, lack of access to professional licensing and lack of English language proficiency'. Furthermore, people have limited knowledge of the job market here. Even people with professional degrees from European countries or the United States and valuable skills and work experience are unable to get employed because of the above reasons. Getting a job in one's own field is particularly difficult. Only 5% of Somali professionals and trades people are employed in their chosen fields'. Many become caught in a cycle of depression, isolation and poverty.

### *Social integration*

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

An interview of this study described the situation as follows: "We are like a well bucket cut off in the well ('wadaan ceel ku go'day')". We are cut off from our traditional system and support and, in the new environment, many of us are sinking in depression".

In Somali society, there are few if any class structures. People interact easily and without formality regardless of their social position. People are used to dropping in on friends and neighbours without prior arrangement. In Somali society parents enjoy a lot of social interaction and get ready help in looking after their children. In Canada, parents (often single mothers) feel isolated; most of their time and energy being drawn to household chores and child care. Isolation is a common theme frequently repeated by Somali mothers.

The Somali community is confronted with new challenges and has difficulty to address the needs of individuals and families. Efforts are further hampered by scarcity of resources.

### *Service utilization*

There are significant differences between Canada and Somalia in social and health service availability. In Canada there are far more such services and in greater variability than in Somalia. In Somalia people are used to relying more on the support of family and friends for emergency or non-emergency help.

In Canada, there is less individualized support from members of the community because often there is no one who has the right information or the necessary means to access services.

Significant number of Somalis ignore the existence of certain services. Such services were not available back home with the result that they are generally quite underutilized here. Even when people know of the existence of specific services, they may not know how and where to get them. This induces many to simply desist from seeking help. Often people tend to drop in without appointments expecting to obtain service immediately. Language barriers and the formality connected with service delivery discourages some people from using non emergency services.

### *Immigration policy*

Canadian immigration policy is viewed as highly stressful and penalizing to the community. Most Somalis feel strongly disadvantaged and prevented from competing fairly with other newcomers. Somali refugees are obliged to remain without legal status for five or more years unless they produce "proper identification documents". However, many complain that they have genuine identification documents but immigration officers would refuse to accept them.

There are many cases of people living and working in Canada for ten years or more without being granted the right to live permanently in the country. This is characterized as discriminatory government policy directed to the community.

A large number of Somali youth are prevented access to higher education because of their lack of landed status. Adults and youth both report high stress levels related to the jeopardy aspect of their employment; their education and their future immigration status. After years of being here, many have still the feeling of being refugees<sup>10</sup>.

### ***Racism/discrimination***

A study on Somali refugees in Toronto showed that about 50% of respondents reported some form of social prejudice or discrimination because of their colour<sup>5</sup>. The heavy presence of Somalis in certain neighbourhoods has occasionally generated racial tensions between Somalis and other groups. Experiences of discrimination were reported in different circumstances such as in the application for housing and employment as well as in the work place. Most of the time, discriminatory incidents are not reported with no redress occurring as victims are unfamiliar with Canadian human rights legislation<sup>5</sup>. Lack of access to information is a major barrier for many Somalis.

### ***Concern about events in Somalia***

In the community there is concern about the situation in Somalia. The welfare of family, friends and others and the lack of peace and stability is causing anxiety and feeling of powerlessness.

### ***Loss of status***

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

### ***Health***

After having endured hardship in their homeland and in refugee camps, many Somalis arrive with a variety of health problems". After settling in Canada, however, physical health improves dramatically due to better medical care, nutrition and improved diet.

For many Somalis, however, sound mental health remains problematic due to posttraumatic stress disorder (PTSD); personal anxiety and depression associated with persecution suffered at home; pattern and difficulty of settlement and adaptation.

### **3. NEEDS ASSESSMENT**

#### **i) Methodology**

The needs assessment was done by the following methods: review of relevant literature, onto-one interviews with key informants, focus group discussions and case studies.

##### ***1) Review of relevant literature***

Literature survey was done through searches in relevant data bases such as MEDLINE, Metro Toronto Reference Library; University of Toronto Robarts and Gerstein Libraries, York University and the library of the Addiction Research Foundation. A search was also conducted through the Internet. Information regarding published and unpublished reports or articles relating to mental health of Somalis was requested from all persons interviewed as well as from all participants in focus group discussions. In addition, institutions visited or contacted by telephone were approached for information regarding literature addressing the mental health of Somali communities here or elsewhere. Searched information also included programs that had been (or were being) developed for the benefit of the Somali Community in Ontario. The collected information is incorporated in the report and when relevant is referred to in the *References*.

##### ***2) One-to-one interviews***

Interviews were held with 24 key informants. These included physicians, community workers, religious leaders, teachers, consumers/survivors, relatives and friends of individuals with mental health problems and relevant staff in community health centres and in research and psychiatric institutions. A questionnaire was developed and circulated for comments. After adjustment the questionnaire was tested before actual interviews were carried out. Sample of the questionnaire is attached to this report as *Attachnlefrt II*.

##### ***3) Focus group discussions***

Three focus group discussions were held. Participants in the first meeting were representatives drawn from mainstream mental health stakeholders, the reference group and the Somali community. The second focus group was drawn from relevant Community Health Centre staff, local Toronto hospitals and Somali key informants. The third group of participants were relatives and friends of people who had experienced some degree of mental health problem or illness. See *Attachment III* for participants in focus group discussions.

##### ***4) Case studies***

A total of three case studies were conducted. These involved interviewing close relatives of mental health consumers. In one case, questions were also posed directly to the consumer. Questions asked related to the type of mental health problem, when and where it started, what factors contributed to the development of the condition, the diagnosis, the barriers

encountered in seeking help, problems related to care by family members, kind of care received and needs being felt at the time of the interview.

Efforts were made to include individuals of different age and sex. Given the nature and sensitivity of the topic, it was difficult to recruit family members to talk about mental health problems of relatives. Case studies involved two men and one woman. Upon the request of families and consumers, interviews were carried out in the home, during a quiet period and only with the interviewer and immediate family present. See *Attachment IV* for the description of the cases.

## **Assessment Outcome**

### ***i) Research and reports***

Very little has been done so far to study the mental health status and needs of the Somali community in Toronto. Key informants reported that in the last three years the number of suicides appears to have increased significantly in the community. This alarming number of suicides and other mental health related incidents or episodes has aroused concern in the community and within mainstream health institutions in Toronto.

Currently there is a needs assessment study underway by Family Service Association and Community Resource Consultants of Toronto.

A research project on mental health in three communities including the Somali Community is now in process in Ottawa. A first phase involving needs assessment and health promotion strategies has been completed".

Not much has been produced in the form of reports or published articles. A pilot study of the health and social needs of the Somali Community was conducted by the City of Toronto in 1992". A study on the mental health of Somali women refugees has also been recently completed<sup>10</sup>. Two small studies on the use of khat (*Cathy edulis*) in Toronto have also been done<sup>13, 14</sup>. A general study on the Somali Community was done in 1991 in the former City of York<sup>3</sup>.

General studies on the mental health of Somali communities appears to be very scarce. A research study on mental health of Somali seniors conducted in the U. K." and a short report on the need to encourage service utilization by the Somali Community in Australia" were also found.

### ***ii) Risk factors***

As seen in the section, *Difficulty of Life in Canada*, Somali-Canadians are faced with a number of challenges that place the community at a high risk of developing mental health problems. ***Key challenges include coping faith pre-arrival traumatic experiences, unemployment, restrictive immigration regulations and policies, social isolation, racism and discrimination, lack of family supports and loss of status.***

Additionally, there are specific factors that cause trouble and distress to individuals with a mental health problem and/or to their families and children at the initial onset of mental illness.

#### ***Lack of early identification and appropriate diagnosis***

Proper intervention often does not occur during the first episodes of mental illness. A critical concern or barrier is the western definition of mental illness and the understanding that the average community person has of the subject. This frequently leads to more serious problems in later stages of the illness. Misinterpretation of symptoms and wrong diagnosis due to cultural and language barriers have been reported by some key informants. This was also confirmed in our case studies

#### ***Lack of information and support for family members and care givers***

Caring for a relative with mental illness is a big emotional and financial burden. Our case studies show the anguish and stress put on a supporting family member. In our study discussions, this issue was raised repeatedly. Supports include access to information, resources, networks and professional health care providers.

#### ***Substance use/abuse***

There is a community perception that the prevalence of substance abuse is lower among Somalis when compared to the general population in Canada. However, informants felt that this problem was on the rise. The substances mentioned were mainly khat, used by people of different gender and age, crack, cannabis and alcohol which were seen to be more prevalent in use among young people. *Khat* is a leafy drug originating from East Africa and the Arabian peninsula. It is used for its stimulating effect and is consumed by chewing the leaves.

Often in diagnostic history taking, questions about non-prescription medicines are not asked. Particularly, khat is little known among health professionals and therefore, problems related to its use may remain undetected. Service providers appear to miss asking questions about the use of herbs and other traditional treatments. This may affect efforts to lead the individual to wellness.

#### ***Non-compliance with treatment***

Many consumers are not conscious of the importance of following strictly and completing their initial treatment regimens. Some consumers discontinue treatment if they do not see immediate results even though it may take weeks for many psychotherapeutic agents to produce a discernable effect. Discontinuation also occurs after improvements have been observed because of the belief that health has been regained and the medication is no more of use. Non-compliance with treatment occurs because many clients simply cannot afford to pay for their prescriptions.

#### ***iii) Service Barriers***

Somalis encounter barriers that make it difficult for them to use mental health services. Some of these barriers touch more closely the Somali community while others are shared with other

newcomer communities. The following are seen as the most crucial barriers against optimal use of mental health services.

### ***Cultural and language barriers***

It is reported that some service providers are unable to engage clients on any but their own cultural terms. The lack of knowledge about Somali cultural perspectives makes it difficult for service providers to understand if certain aspects of the consumer's behaviour are cultural or mental health related. This may lead to wrong diagnosis and lack of or wrong treatment. Health professionals apply their knowledge and skills often without taking into account perceptions, feelings and cultural background of individuals. The lack of cross-cultural psychiatrists is a real concern.

Additionally, it is important in many cultures to have the availability of ethnoracial-specific mental health workers with full language ability. This appears to be particularly important for the Somali Community. Many people feel uneasy or unwilling to seek help or talk of their problems in institutions where none of the staff belong to their culture or speak their language. A large number of Somalis lack a sense of belonging and trust in centres where their feelings are not understood. Proof of this can be found in the high number of Somali clients found in the few Community Health Centres that employ Somali workers.

The lack of effective cooperation between mental health providers and Somali community agencies is an additional constraint.

### ***Information gap***

Lack of communication and understanding of how the mental health system works creates for many people difficulty accessing the services they may or might need. Furthermore, it is not enough to make information available. The response of consumers and families indicated that the presentation of information was critical to accessing services and gaining their trust.

### ***Stigma***

Stigma associated with mental health problems is widespread in many cultures. Mental health problems are often treated as a family secret that should not be disclosed. Sometimes even health professionals may not be fully informed. This reaction may be a denial of the existence of a mental health problem in the family and further exacerbate the condition.

### ***Mental health legislation***

Existing legislation creates difficulties for many wanting to access treatment. Current law protects the right of consumers to accept or refuse treatment, however, families and service providers report that some consumers miss needed treatment because of lack of appropriate consents. Lack of information, cultural and language barriers make this problem more critical for the Somali Community (see *Attachment IV: Case studies*).

### ***Racism and discrimination***

Racism and discrimination are reported to be a major contributor to mental health problems". Racial discrimination in various forms were reported by community members.

Service barriers were reported as providers being untrained in valuing or being sensitive to cultural differences of consumers. Stereotyping was reported by a number of Somali families. Some service providers tended to patronize minority consumers. Furthermore, perceived institutionalized racism makes it difficult for a significant proportion of the community to comfortably access services.

### ***Limited case management and follow-up support***

Some consumers do not have a full understanding of the management of mental health problems and what they are required to do to help in their own recovery. Reported problems included: limitations of some case management services and lack of appropriate and sensitive follow-up and support. Lack of follow-up was cited as a cause of non-compliance with treatments.

### ***Referral problems and delays in service delivery***

Access to services was identified as being hampered by a lack of referral to locally available services and appropriate providers. In addition, waiting times for consulting a specialist are long; it may take 6-7 months for an appointment. Many drop out of treatment because of this.

### ***iv) Identified needs***

Project consultations evidenced many shortcomings in the existing mental health system, particularly its capacity to serve equitably all segments of society. Data from research on Somali refugees in Toronto shows that a significant number suffer from psychological conditions such as unresolved grief, constant stress, anxiety, nervousness and fatigue'. In spite of the pervasiveness of these conditions, a majority of respondents had not sought medical assistance. Almost all project participants were of the opinion that members of the Somali community were having great difficulty accessing resources and getting needed services. Particularly relevant needs are:

### ***Use of Somali workers as mental health service providers***

Cultural and language barriers and lack of trust keep many Somali consumers away from accessing mental health services. For access to service it is necessary to have trained Somali workers (case managers, counselors, etc) employed in mental health centres, particularly in those areas where there is a high community concentration. Resources need to be directed to on-the-job training and other measures which prepare Somali professionals to assume jobs in the mental health field.

Non-Somali staff of community health centres and hospitals should be educated about cultural needs of Somali individuals and their families as well as receive training in the area of anti-racism. In addition, a client-centered approach that recognizes the uniqueness of each

individual together with the use of cultural interpreters, could help support culturally sensitive services.

### ***Cooperation between Somali Community agencies and mental health institutions***

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

### ***Advocacy***

The Somali Community is still new to Canada and lacks the experience and support of more established communities. With so many of its community members exposed to traumatic experiences and the challenges of every day life in Canada, there is a need for increased advocacy to build awareness and improve access to mental health services.

### ***Recruitment of Volunteers***

Somali volunteers should be recruited to carry out community outreach work. Although volunteers work to help their community by donating their time, consideration should be given to supporting their work e.g. honourariums, incentives, refund of transportation and other expenses.

### ***Educating family physicians and other health professionals***

Family physicians and other staff working in hospital emergencies and community health centres need to know more about the Somali Community. Education should be aimed at improving the understanding of cultural perspectives and the distressful experiences that many Somalis have gone through before arriving in Canada. Where appropriate private practice physicians should consider referring patients with mental illness to service providers that have Somali speaking staff, such as community health centres. Physicians should be encouraged to take a holistic approach, that takes into consideration environmental and emotional factors, in their diagnoses and treatment of mental disorders.

### ***Choice of 'Threatening***

Many Somalis have negative feelings about conventional methods of treatment. Many are convinced that medicines (particularly injections) produce effects which are worse than the untreated condition. They feel more comfortable with alternative treatments which are often not covered by OHIP. Consideration should be given to extending coverage to some forms of alternative treatments.

### ***Licensing of foreign trained Somali health professionals***

There are no licensed Somali physicians, psychiatrists or mental health providers in the

existing health care system. This continues to be a critical barrier to service access for the community.

Somali community agencies with the support of other groups should lobby with the provincial Ministry of Health, appropriate professional bodies and associations to alleviate licensing barriers and introduce a way to fast-track the accreditation of foreign trained Somali professionals.

### *Establishing support services*

One of the major difficulties that consumers and their families are confronted with is the lack of support services. Particularly needed are ***suitable housing, recreational facilities, vocational training and rehabilitation programs*** for Somalis with mental health problems. Many homeless Somalis including those with mental health, drug and alcohol abuse problems, need boarding homes that are culturally appropriate. This is extremely important in dietary observation (halal food preparation, Ramadan observances) and religious life (call to prayer, congregational prayers, counseling). In order to attract consumers from the community to use such services and for better socialization, boarding homes targeted to serving mainly Somali consumers and staffed by Somali providers should be established.

A large number of Somalis lost all belongings in their civil war, additionally they have not been in Canada long enough to establish a solid economic base. Many individuals are unable to pay for their prescriptions when these are not covered by OHIP. Our case studies and opinions from experts in this field show the need for financial support to poor or low-income consumers and their families.

### *Establishing a Somali Mental Health Support and Action group*

Within the Somali community there is much discussion on mental health problems, however, there are currently few forums for advancing action in the area. The establishment of a Somali Support and Action group for mental health would help to improve system advocacy and contribute effectively to community support and focus on the issues and problem.

## 4. Health promotion strategies

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

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

Suggested strategies include 1) community education and 2) training of front-line service providers (mental and non-mental health systems).

### ***1) Community education***

Programs should aim at promoting a better understanding of mental health and an increased awareness and access to mental health services. Education and information should be made available to the community through:

*~ Printed material.* Culturally and linguistically appropriate educational material such as regular newsletters, flyers, articles on mental health through community newspapers.

*1) Video formal.* Short programs in video cassette format that present mental health in an appropriate cultural perspective should be produced. These would be convenient for private viewing as well as for use in training programmes and for presentation at community gatherings.

*iii) Radio programs.* Transmission of a series of mental health programmes should be established using community radio. This type of outreach often generates community discussion and past experience with the media indicates a sizeable Somali audience will turn on to listen.

Educational material and programs should convey information on what is mental illness, how to identify problems, when to seek help, where to go for assessment and treatment, what support is available for families of consumers/survivors, treatment benefits and drawbacks. Education programs should address the issue of children's mental health - a high priority for families.

### ***2) Training***

#### ***i) Training of Somali front line workers***

Front line workers outside the mental health system are currently under a lot of stress and

frustration due to the demands and scope of the problem. They are often without knowledge or experience in dealing with issues, individuals and their families or the system itself. Training for this group should focus on recognizing problems, helping clients access appropriate services as well as orientation to the mental health system. A manual for this group should be developed with the help of Somali professionals and main stream service agencies.

*ii) Training of trainers*

The viability of a train the trainer program as a strategy for enhancing the community's capacity in the area of mental health awareness, information and education should be considered. A number of possible models are available through health related databases and health promotion programs.

*iii) Training of Somali high school students*

Most Somali households have family relationships with one or more high school age students. They are often the ones who speak the best English in their family. Training of high school students on the mental health system and on mental health problems could be an important way of raising family and community awareness. Due to their Canadian education, cultural background and credibility within the family circle, a training program aimed at informing and supporting students on mental health issues should be considered.

## **5. RECOMMENDATIONS**

This Project has identified a need to put into effect various measures that can be aimed at the prevention of mental health illness and problems and at improvement of access to mental health services that would benefit the Somali community. Implementation of

recommendations found in the report will require funding, resources as well as the cooperation of different institutions and community agencies. Most of the recommendations are directed to Toronto's Community Health Centres or to Somali community organizations.

Partners and stakeholders expected to take part in implementation include: Canadian Mental Health Association (CMHA), Canadian Centre for Victims of Torture (CCVT), community and hospital based mental health service providers, City of Toronto Board of Education, University of Toronto, University of York, Centre for Addiction and Mental Health and City of Toronto social housing agencies.

### Advocacy and Public Education

- 1) THAT a Mental Health Education and Awareness Program for the Somali community be developed and implemented.
- 2) THAT a Somali Resource and Consultation Service be established with the goal of assisting mental health service providers a) improve access to mental health services and b) service and program delivery
- 3) THAT current Federal Government immigration restrictions affecting Somali refugees be amended to allow for a more expeditious granting of legal landing status and family reunification.
- 4) THAT barriers for licensure of foreign trained Somali professionals be alleviated and that Skills Development Programmes that target Somali newcomers be implemented.
- 5) THAT Somali Community Organizations and Community Health Centres develop and implement an Advocacy Strategy with the goal of creating community awareness and empowerment in the area of mental health.

## Service

- 6) THAT Community Health Centres recruit Community Mental Health Workers so as to provide outreach services to the Somali community.
- 7) THAT closer links and cooperation be established between Somali Community Organizations and Mental Health Service Agencies.
- 8) THAT ethno-specific Somali Mental Health Workers be recruited to positions within the mental health system.
- 9) THAT ethno-specific support services in the areas of residential/recreational facilities, vocational training and rehabilitation be established with the goal of targeting Somali mental health consumers.
- 10) THAT Community Support Programmes be developed that provide emotional and financial support to Somali families caring for the mentally ill.
- 11) THAT treatment models for mental illness be developed that reflect traditional Somali values , beliefs and practices.

## Research

- 12) THAT a Children's Mental Health Research Project be developed to investigate the mental health needs of children within the Somali community.
- 13) THAT a quantitative Research Project be developed and implemented to assess the extent of mental health illness and problems within the Somali community.

## 6. REFERENCES

1. Graham Report - Building Community Support for People: A Plan for Mental Health in Ontario. Ontario Ministry of Health, 1988.
2. After the Door Has Been Opened: Mental Health Issues Affecting Immigrants and Refugees in Canada. Report of the Canadian Task Force on Mental Health, 1988.
3. Siad A. "Findings on the Somali Community in the City of York" - York Community Services, 1991.
4. Yahoo Internet site: Somalia, March 1999.
5. Opoko-Dapaah E. "Somali Refugees in Toronto. A Profile". York Lanes Press. Toronto, 1995
6. Yusuf H.L, Adan A.,Egal K., Omer A., Ibrahim M.& Elmi A.S. "Traditional medical practices in some Somali communities" in Journal of Tropical Pediatrics
7. Elmi A.S. "Use of plants in Somali traditional medicine" in Proceedings of the Second International Congress of Somali Studies" University of Hamburg 1983.Helmut Buske Verlag Hamburg
8. Somalians in Canada. A Guide for Health and Services Providers. Sandy Hill Community Health Centre, Vanier, Ontario, 1991.
9. Midaynta, Association of Somali Service Agencies "Somali Professional and Trades People Study" - Preliminary Report -August 1998
10. Ruff S. "After the crises: An exploration of humanitarian workers' and Somali refugee women's narratives of `health'". Masters of Arts, York University, 1998
11. Kendall P.R.W. "A pilot Study of the Health and Social Needs of the Somali Community in Toronto" Department of Public Health, City of Toronto 1992
12. A Pilot Project in the Chinese, Ethiopian and Somali Communities - Mental Health for New Canadians Project 1997. Pinecrest-Queensway Health and Community Services in collaboration with C.M.H.A, Ottawa-Carleton Branch
13. Jowhar S. "Khat - It's Social, Economic and Health Problems" - Somali Family and Child Skill Development Service - The City of Toronto - 1995
14. A Preliminary Study on the Social, Economic and Health Consequences of the Use of Khat - Parkdale Focus Community and Rexdale Community Health Centre 1999
15. Silveira E. & Ebrahim S. "Mental health and health status of elderlyBengalis and Somalis in London" in Age and Ageing 24:6, 1995
16. Ghiani B and Stankovska M. "Community Education The Somali Experience" ADEC News - Australia - Winter 1998.
17. Durbin Janet et al" Improving Mental Health Supports for Diverse Ethno/racial Communities in Metro Toronto" - A Community Planning Project, sponsored by Metro Toronto District Health Council 1992

QUESTIONNAIRE

*This questionnaire is part of a research on the mental health status, needs and services for the Somali Community in Toronto (SCT). The Project is in partnership between York Community Services and Rexdale Community Health Centre.*

Name of respondent \_\_\_\_\_ Institution \_\_\_\_\_

Gender M /- / F / / Occupation \_\_\_\_\_

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1) Do you know of any studies or reports on the mental health of the SCT?  
YES describe  
No if the answer is YES please

2) Please make a list of what you consider as the main mental health problems in the SCT?  
*(in accordance with your experience or information which has come to your attention)*

3) Do you think that mental health problems occur more often among Somalis here in Toronto as against people living in Somalia?

- more often here
- about the same
- more often in Somalia
- no opinion

4) Do you think that there are some types of mental health problems that occur more in the SCT compared to the mainstream society of Toronto?

Yes NO  
if the answer is YES please give examples

5) What are the difficulties that, generally, Somali-Canadians with mental health problems and their families encounter when seeking mental health help?

6) Which groups in the SCT are mostly experiencing mental health problems or are seeking help for such problems? Please check off 3 of the following

- children
- youth
- adult women
- adult men
- seniors
- single mothers
- other (specify)

7) In your opinion, what are the factors that elevate the risk for experiencing mental health problems in the SCT? Please describe or make a list

8) Do you think that in the SCT, people generally know what services and programs are available for mental health problems?

Yes \_\_\_\_\_ No \_\_\_\_\_

if the answer is NO, what would be the best way to deal with the problem?

9) Are there ethnocultural factors that may affect positively or negatively the mental health status of the SCT?

- Factors affecting positively

- Factors affecting negatively

10) Do you think that some people experiencing mental health problems in the STC seek help outside the available conventional mental health services (e.g. religious, traditional treatments)

Yes\_

No\_

Don't know\_

if the answer is YES, please describe and tell what you feel approximately to be the percentage of those who seek help outside the conventional mental health services?

11) Do you think that available mental health services and programs are respondent to the needs of the SCT in a culturally appropriate and sensitive manner?

Yes\_

No

if the answer is NO, what do you think should be done? 12)

13) What models of health promotion strategies would you recommend to improve access to mental health services and programs for the SCT?

## *A TTA CHMENT III*

### **FOCUS GROUP PARTICIPANTS<sup>(\*)</sup>**

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Abdurahman Sabriye	Canadian Mental Health Association (CMHA - East)
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Janet Priston Abukar	York Community Services (YCS) Rexdale
Moallim Khadija M.	Community Health Centre (RCHC)
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Leann Gallant Leslie	Canadian Mental Health Association (CMHA - West) Community
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Carnlelina Barwick	Organization (SIAO) CAMH - Clarke Division
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Faduma Awow Mohamed	CultureLink
Barbara Trudell	St. Elizabeth Health Care
Ambaro Guled	Regent Park Community Health Centre
Paul Kwasi Kafele	Across Boundaries
Abdullahi S. Find	York Community Services (YCS)

(\*): The names of the six participants in the focus group for relatives and friends of people with mental health problems or illness are not included in this list.

## Attachment IV

### CASE STUDIES

#### - a) *Case 1*

This case regarded a male, 60 years of age. The subject used to live in Mogadishu where he had a family and a productive life. His problems started in Mogadishu in 1991 when a bomb shell hit his house and killed wife and three children. The tragedy shocked him profoundly and produced in him numbness and detachment from others. All attempts to stimulate him and help him regain contact with reality were to no avail. With lots of difficulties and support from relatives, he was taken to Kenya. He spent there a few years in very difficult condition in refugee camps. Eventually he arrived three years ago in Canada.

In Toronto he is living with a close relative, the same person who had been caring for him since the problems started. They reported miserable life here. For quite a while after arriving in Canada, the subject did not get the needed care for his mental problems. Since he does not speak English, his family doctor doubted of the symptoms reported by relatives and apparently did not give him proper mental health care.

In Toronto the consumer was always kept locked in the apartment where he lives, closely monitored by his relative. He did not show violence, he talked to himself and experienced hallucination episodes.

He escaped twice from the apartment. Once he walked for several miles, bare feet on the snow, and wearing light clothes at below zero winter weather. Another time he went on the balcony sitting on one edge and attracting the attention of passing by people.

It took one year before the consumer was referred to see a psychiatrist. He started taking his medication regularly but did not regain contact with reality. He was not aware of the country where he was living and had huge memory lapses.

His supporting relative did not know the diagnosis of the disorder. She described her life as a nightmare. She is day and night with him with door and windows locked. She said that she went out rarely and only for very important matters. Neighbours helped them with most of the shopping. She could not work or go to school to learn English or acquire skills. She could not enjoy life with others. They did not receive housing, financial or any other support beyond general welfare. She said "I have no life and I cannot abandon my relative in this condition. I am just waiting to get mad myself". She had no idea of what kind of support she and her relative were entitled to. There was no history of mental illness in the family.

*- b) Case # 2*

The subject was a female, 40 years of age. Her problems started at the peak of the crises in Somalia. She lived the events in Somalia with great emotion although she was not living there at the time. She started with paranoid behaviour but her relatives did not recognize the symptoms as a mental health problem. They considered her behaviour as a kind of show off. There was no history of mental illness in the family. When the problems started they were not shared with other people outside the family circle. Denial of the existence of any problem was the reaction to questions regarding the mental health of the subject.

Faith healing and some traditional forms of treatment were applied. It took three years before she was seen in a mental health care centre; this did not happen by decision of the consumer or the family. One day she was stopped by the police as she was showing strange behaviour in a public place. She was taken to a hospital.

She refused to take the medication, threatened her relatives, broke home furniture and had a suicidal attempt. She was hospitalized a couple of other times by order of a justice of peace.

After a long time the consumer and the family understood that she had to comply with the treatment. At the time of the interview she was taking her medication regularly. She was functional but she did not go out on her own and avoided strangers. The family complained that a lot of time was lost before they found out what they had to do. They also said that, if they had received proper information about the illness and its management, they would have more likely complied with the medication regimen, participated in programs intended to help their relative and modified their behaviour in ways that would have reduced the risk of relapse. They hoped that something be done to avoid for others the trouble they went through and that early detection and treatment of mental illness is achieved for everyone.

*- c) Case # 3*

The subject was a male in his thirties. There was no history of mental illness in the family. The first symptoms started while he was student. Luckily his condition improved and he managed to finish his studies and get a job he was satisfied with.

He was living in an area of the Toronto with high concentration of Somalis. His symptoms reappeared in a period when there were racial tensions in the neighbourhood. The relative he was living with reported that the subject reacted, without committing violence, to discrimination events. He was charged and arrested. This stressful fact apparently precipitated his condition. His relative said that although the subject's mental problems were evident, he had to stand trial, was found guilty and placed under probation. He was banned to appear in the area where he was living. His condition deteriorated and was taken to hospital. He refused treatment and was discharged after.