

Development and policy

Imperfect prescription: mental health perceptions, experiences and challenges faced by the Somali community in the London Borough of Camden and service responses to them

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ABSTRACT

Refugee groups experience issues that can affect any community, however, research and data available have highlighted that refugees are particularly disadvantaged in relation to mental health experience and access as a result of political, administrative, language and cultural factors. Discourses on mental health in the context of Western interpretations are not sufficient to understand refugees' interpretations of their own needs, perceptions and experiences of mental health in the UK. This study was established to assess the Somali community's own perception of mental illness and some of the barriers to accessing and utilising services in the London Borough of Camden. The findings are based on qualitative and quantitative methods. Data on service utilisation was drawn from data on users of the St Pancras Refugee Centre, semi-structured

interviews from a sample of seven Somali service users from the above project and with representatives of all the eight Somali community organisations based in the London Borough of Camden. The results indicate that Somali project users make considerably less use of mental health services on the basis of cultural factors and due to pre-occupation with post-migration stressors including immigration status, housing, social and socio-economic factors. This article places these findings within the context of the structures and organisations of the mental health system, and in turn adds to the knowledge base on good practice and service delivery.

Keywords: Camden, inequalities, mental health, refugees, transcultural mental health, service provision, Somali

Introduction

Refugees and asylum seekers often have complex and multiple needs, are amongst the most marginalised, vulnerable and socially excluded people in our society and are particularly disadvantaged in relation to mental health experience and health

access.¹⁻³ These disadvantages are complicated by the fact that they are likely to be linked to both the personal and institutional migration process and subsequent experiences within institutions, which may culturally disadvantage them.⁴⁻⁶ Refugees are

not a homogeneous group, varying in nationality, ethnicity, socio-background and culture, and consequently they differ in how they express their needs.⁷ Approaches to mental health vary between cultures, and behaviour can be interpreted in different ways depending on the cultural setting; this often results in diverging diagnoses.^{3,6,8} Fernando has highlighted that mental health users from minority ethnic groups access and utilise mental health services differently from 'white groups'.⁸ This paper focuses on the experiences of the Somali community residing in the London Borough of Camden.

In focusing on Somali refugees in Camden, this paper will examine the specific difficulties and challenges this group have in accessing and utilising mental health services. This process is analysed within a theoretical framework, to especially include concepts of racism and institutional racism. Information was gathered from literature, from data on users of the St Pancras Refugee Centre (SPaRC) and from interviews recently undertaken with refugee community leaders of the eight Somali organisations in Camden, and from a sample of seven Somali users of the St Pancras Refugee Centre. The St Pancras Refugee Centre is a 'one-stop shop' based in Camden, London, and has been fully operational since January 2000. The project offers a 'holistic' response to the needs of refugees, providing advice and advocacy, social and emotional support, and access to health services, education and training. Providing holistic support is acknowledged to be an appropriate way of delivering quality care to refugees.⁹ Services are provided at the project's base in King's Cross and through a number of outreach advice surgeries. There is a particular focus on users' mental and physical health issues, and it acts as a lifeline to those that have been, or perceive themselves to be, excluded because of their mental health problems. The services are user led and therefore culturally appropriate. The project is the only generic refugee project in the borough, which is accessed by a multicultural client group and is therefore uniquely placed to provide information on refugees in Camden, London.

The format of this paper will be to initially outline the challenges presented by the mental health issues of this specific black and minority ethnic (BME) group in terms of access and use. This information will then be placed within the context of the structures and organisations of the mental health system, and in turn adds to the knowledge base surrounding good practice and service delivery. It must be stressed that the findings do not provide a comprehensive study, and due to size limitations is not claiming to be representative of the Somali refugee community as a whole.

The Somalis in Camden

The Somali history of forced migration is directly related to the armed conflict that began with civil war and conflicts of the 1990s, through to the regional violence and insecurity that has continued into this decade.¹⁰ The Somali community is recognised as the largest refugee community in the Borough of Camden and the second largest 'non-white' minority after the Bengali community.¹¹ Khan and Jones also describe a community that is very deprived in terms of social exclusion, with services failing to respond to overt and extreme levels of need.¹¹ It is difficult to determine the precise number of Somali refugees living in the Borough of Camden, however estimates (now certainly out of date), put the number at 4000 with 1900 recorded as born in Somalia in the 2001 Government Census figures.¹¹

The report by Khan and Jones on the Somalis in Camden identifies a community, which strongly identifies with its religion and cultural traditions.¹¹ Griffiths, in *Somali and Kurdish Refugees in London*, also comments on a clan-based Somali community structure, which replicates such groupings in Somalia.¹² These groups often stand alone and contribute to the fragmented nature of the wider Somali community, which limits political cohesion in exile and consequently weakens their ability to act as an effective pressure group for change. In addition, these separate groupings can act in a divisive way and therefore discourage open and equal access.

There is a lack of population-based evidence on the prevalence of mental illness amongst the wider Somali community; however, evidence available from research suggests that poor access to health care is a major problem for the Somali community. This wider context suggests that the mental health needs of this group generally, are being overlooked. Research evidence, experience and knowledge of mental health issues gained from Somali community groups are an important supplementary source of information. A study by McCrone *et al* highlighted the prevalence of mental illness amongst Somalis living in London, with issues ranging from stress and anxiety to suicide.¹³ The same study reported that although this community had a high level of needs, access of services were low.¹³ A serious consequence of this is that depression, anxiety, post-traumatic stress and other Western diagnostic labels are not regularly recognised in Somali health care, and can therefore impact on individuals' willingness to access health care and treatments.¹³ In their study on Somalis in South London, Warfa and Bhui reported that 'mental disorder was often considered

to refer to madness or to severe forms of mental illness including disturbance and being out of control, and mental illness was not applied to depressive experiences'.¹⁴ In East London, older people of Somali ethnicity were found to have a higher prevalence of depression when compared with 'white groups' of a similar age.¹⁵

Methods

In this research a multi-method approach was used to address the research issues. A multi-methods approach is most commonly referred to as 'triangulation' and it refers to the use of multiple methods in the study of the same subject.¹⁶ Denzin, commenting on the above method, recommends that sociologists should examine research findings from as many different methodological perspectives as possible.¹⁷ The benefits to be gained from the multi-method approach include obtaining broader and better results, and adding rigor and depth to any investigation.¹⁸

Information was sought from project statistics, project users and community groups. The majority of the data was collected via in-depth semi-structured interviews. The use of semi-structured interviews allows respondents to feel in control, as they can determine the pace of the interview, and it may also result in an openness concerning difficult and sensitive issues. Seven (male = 3, female = 4) Somali users of the St Pancras Refugee Centre, were selected from project users as part of a postgraduate study undertaken with ethical clearance from the University of Kent. All participants lived in the Borough of Camden. The mean age was 34 years. All participants were unemployed and five were in receipt of welfare benefits, one was without support and one was in receipt of NASS subsistence support. Education and English language ability levels varied from low to good. All reported that they were single in the UK, however, four of the seven participants were married, with their spouses either deceased or 'missing'. All participants were first generation migrants. Three of the users (male = 1, female = 2) had a mental health diagnosis.

The St Pancras Refugee Centre is currently undertaking research for Camden primary care trust (PCT) on the mental health needs of refugees in Camden. The project 'Identifying the mental health needs of refugees in Camden' involves interviewing all 58 refugee communities in Camden. This research project explores the relationship between refugee community organisations (RCOs) and the provision of mental health service. Interviews with all eight

Somali communities have taken place and the findings are used in this study (see Box 1). The complete research is expected to be completed by June 2006. Interviews with service users and Somali groups covered the following main themes: their understanding of the kinds of distress in their communities, their understanding of appropriate responses to this distress, and how they thought service planners should be responding. Responses were analysed using the framework method.¹⁹ Data arising from the interviews with services users and those from interviews with community groups were analysed separately, though the resultant frameworks developed for charting and interpreting data were compared. Codes and frameworks were rooted in the aims of the project, and guided by the nature of the interview data generated.

The debate on transcultural mental health reveals there are numerous possibilities for misunderstanding and miscommunication at both linguistic and cultural levels. Even if communication is successful, there is a risk that the level of stigma associated with mental ill-health may prevent individuals and some RCO leaders from acknowledging its presence, or if acknowledged, its level. To accommodate the need for cultural and possibly linguistic interpretation, we involved second interviewers who were experienced Somali community workers in Camden (interviews were undertaken by Ermias Alemu in conjunction with Somali community members). Confidentiality has been maintained throughout this article.

The quantitative data from users of St Pancras Refugee Centre was primarily used to establish a context and allow for an analysis of the probable extent of the issues raised during the qualitative research process. The project collects detailed data on all those to whom it provides a service, including age, sex, nationality, first language, level of spoken English, residency status, housing status, address, borough of origin, health and disability issues, care plan, referrals made and outcomes. This is recorded

Box 1 Projects interviewed

- Somali Community Centre
- Somali Elderly and Disabled Centre
- Somali Self-help Group
- Somali Peace of Mind
- Somali Women's Project, West Hampstead Women's Centre
- Somali Youth Development Resource Centre
- Somali Education and Development Agency Camden (SEDAC)
- Somali Children and Adult Education Service

on a database that was custom-made for the project, which can produce statistical reports relevant to each funding source. The quality and effectiveness of the project's outputs are measured by questionnaires and consultations with users and through informal feedback. For this study, data on the project were analysed using the project's database for the 6-month period between April and September 2005. Between April and September 2005, the project had undertaken comprehensive casework with 100 Camden residents of 19 different nationalities.

Findings

The St Pancras Refugee Centre is a key focus for Somali residents in Camden with users from this group comprising 37% ($n = 37$) of the total ($n = 100$) Camden resident client group in the period April 2005 to September 2005 (see Box 2).

Although the Somali ethnic group make up the largest number of users (37%, $n = 37$) for the above period, only five users were receiving treatment from secondary health services (see Table 1). Categories of mental health issues more common amongst Somali users of the St Pancras Refugee Centre as diagnosed by primary and secondary health providers include mild and moderate depression. These are noted as being considerably lower than for other ethnic groups; however, due to size limitations, this paper does not offer an analysis of the issue of health access of the Somali community in comparison to other minority ethnic groups. Interestingly, of those

Somali service users accessing primary and secondary health services, the majority were living in temporary or insecure housing conditions. Of those Somalis not accessing health services ($n = 25$), 11 informed project workers that they had been subjected to pre-migration traumatic experiences including beatings, rape or seeing family or friends killed or mistreated.

'Everything is lost and broken. So many were killed, beaten and shot. Women raped, beaten and shot. Men killed, missing, wives and children missing. I can't think about it but I do and cry all the time. It's the reason why we are here in UK.' (SPaRC service user: single Somali female aged 30 years, not accessing any health services when first approached the project)

Flashbacks, nightmares, concentration difficulties and headaches and a feeling 'of being lost' were common complaints of the Somali users interviewed for the research.

'When I walk down the street I think I am in Somalia. I get lost and don't know where I am. I hear a voice in my head and I feel very afraid. I am not normal. I think I am a mad man.' (SPaRC Service user: single Somali male aged 47 years, not accessing any health services when first approached the project)

Service users and community groups interviewed reported that the Somalis in Camden encounter barriers, which makes it difficult for them to access services. Fear and mistrust of the system, language difficulties, pre-occupation and anxieties about immigration status and housing and income outcomes

Box 2 The St Pancras Refugee Centre Project

The project has worked with over 500 Somali nationals from January 2000 to September 2005. Between April and September 2005 the project had undertaken comprehensive casework with 100 Camden residents of 19 different nationalities. The largest groups were Somalis (37%, $n = 37$), Ethiopians (12%, $n = 12$), Iranians (11%, $n = 11$), Kosovans (9%, $n = 9$), Congolese (9%, $n = 9$), with the remainder coming from other countries in the Middle East, the former Soviet Union and from other parts of Sub-Saharan Africa.

Of the total number, 58% of people using the project during the above period were assessed as suffering from mental health issues and were receiving treatment by primary and secondary care services and other specialist refugee agencies. Post-traumatic stress disorder (PTSD), anxiety disorders and various degrees of 'depression' are by far the most commonly diagnosed psychiatric disorders among the project's client group. The severity of PTSD is linked to factors including the intensity of the event, support factors, bereavement and previous traumas, and is usually accompanied by depression, substance abuse or anxiety and suicidal tendencies. Of the 100 clients, 27 users were diagnosed as suffering from, and receiving treatment for PTSD; however, this high number may be due to the fact that the project has established partnerships with specialist clinical settings. Eighteen of those users diagnosed with PTSD were also receiving treatment for major depressive disorders, with six viewed as having suicidal ideation. Thirty-six project users were receiving treatment for mild or moderate depression, with almost half diagnosed as suffering from 'reactive' rather than 'biological' depression.

Table 1 Mental health categories of Somali users – St Pancras Refugee Centre April to September 2005

Male/ female	Age (years)	Nationality	Housing tenure	Immigration	Depression (mild/ moderate)	Severe depression disorder	Suicidal ideation	Psychosis	PTSD	Treatment
M	43	Somali	Friends	ILR						
M	43	Somali	Friends	ILR						
M	62	Somali	Council	ILR						
M	40	Somali	Council	Refugee						
M	25	Somali	Council	ILR						
M	29	Somali	Hostel	A/S	X					
F	51	Somali	Council	ILR	X					
F	18	Somali	Council	ILR						
M	51	Somali	Council	ILR						
M	28	Somali	Hostel	A/S	X					
M	29	Somali	Friends	ILR						
M	21	Somali	Hostel	ILR	X			X		CMHT
F	60	Somali	Council	Citizen						
M	19	Somali		A/S				X		Hospital
M	35	Somali	Council	ILR						
F	27	Somali	Council	Refugee						
M	63	Somali	Bed and breakfast	Refugee	X					
F	38	Somali	Private	Citizenship						
M	42	Somali	Private	Refugee						

Table 1 Continued

Male/ female	Age (years)	Nationality	Housing tenure	Immigration	Depression (mild/ moderate)	Severe depression disorder	Suicidal ideation	Psychosis	PTSD	Treatment
M	47	Somali	Council	Refugee	X					
F	27	Somali	Council	ILR						
F	31	Somali	Council	CIT					X	CMHT
M	31	Somali	Friends	ILR						
F	60	Somali	Housing association	ILR						
F	42	Somali	Hostel	Refugee	X		X		X	Traumatic stress clinic
F	26	Somali	Private	ILR						
F	38	Somali	Council	Refugee						
M	24	Somali	Friends	Refugee	X					
M	42	Somali	Hostel	ILR						
M	31	Somali	Council	ILR						
M	35	Somali	Friends	A/S						
F	30	Somali	Hostel	Refugee	X					
M	23	Somali	Council	Citizen						
M	51	Somali	Private	Refugee						
M	19	Somali	Friends	A/S						
M	35	Somali	Hostel	A/S		X		X	X	CMHT

A/S, asylum seeker (claim pending); CIT, citizenship granted (British); CMHT, community mental health team; ILR, indefinite leave to remain.

were some of the reasons as to why many did not access mental health services. The need for practical solutions to social, legal and economic difficulties was identified by all of the interviewees. Primary care services were also seen to provide an 'imperfect prescription' in terms of the often limited solutions or options provided to possible physical and/or mental health issues.

'I have a big big problem with housing and status. I need a place to sleep. It's getting cold and I am tired moving from place to place. I also need money for food and clothes. My family are missing. I'm always looking for information about them. The way I live, people could not live like me. I have headaches all the time and the pain is inside like nerve all the way around. I have pains in my foot from the bullets. I am tired. The problem is the GP [general practitioner]. I have problem communicating. He gives me 2 minutes without hearing, and medication. It's not perfect. I don't feel better. He doesn't understand.' (SPaRC service user)

It was also commonly reported that the plight of those suffering from mental distress is exacerbated by lack of support and stigma in their own community. There is also a problem with denial whereby sufferers hide their problems through fear of humiliation or stigma.

'For the overwhelming majority of Somalis, mental illness carries a certain taboo and has associations with madness.' (Somali community leader)

'I don't go to the Somali Centre because everyone knows you and all the people talk. They will talk about your problems.' (SPaRC service user)

One Somali community worker from the Peace of Mind project reported that:

'The stigma attached to mental ill-health attaches to the whole family of the sufferer; they only seek help when the problem reaches a critical stage.' (Somali community leader)

With such support missing, the role of refugee communities and voluntary organisations that work across all communities becomes a crucial support service.

There is also a rising concern about the high suicide rates amongst the Somali community in Camden (see Box 3).²⁰ Community leaders, users and project workers have reported such statements but as yet they only represent anecdotal evidence.

'People are losing ideals and thoughts with no future, and are hiding it. Young men are drinking and spending time feeling so useless and are killing themselves.' (SPaRC service user)

'People keep everything inside. They cannot communicate or talk about the problems, they try to kill themselves. Suicide is rising in the Somali community.' (Somali community leader)

Box 3 The London Borough of Camden

The London Borough of Camden is the most polarised in London, containing ten Neighbourhood Renewal Fund areas, six of which are within the most deprived 5% in the UK. Standardised mortality ratio in South Camden is 60% higher than the national figure and the infant mortality rate double. The mental illness needs index is 20% higher than the national figure, and the suicide rates are the highest in London and amongst the highest in the UK. The suicide rate in the Somers Town ward is the highest in Europe; 75% of suicides in Camden were not in contact with any mental health services (Camden Primary Trust, *Suicide Prevention Report 2004*).

A thorough assessment of suicide among Somali refugees is needed in order to clarify the issue. Although these issues warrant comprehensive research, and the information available is very limited and inconclusive, having a mental illness is a known risk factor for suicide.

Service users interviewed reported finding coping mechanisms in religion and other traditional means. There was a propensity for some of those interviewed to view illness as the will of Allah, which is a possible contributing factor as to why access to Western services is low.

'It's Allah who decides. He knows everything and what has happened and what is inside. Only he knows and will decide what happens.' (SPaRC service user)

These different coping strategies are what Helman describes as the 'popular sector', which can include family members or individuals, and the 'folk sector', which includes faith or religious healers.²¹

Different cultural understandings of health care: the problem of perception – a challenge to both Somali users and service providers

Unless cultural interpretations of distress are taken into consideration, communities will not access services, misdiagnosis may occur, and everyday mental distress can be mistaken for mental pathology.⁶ The interviews with the professional community

workers all drew attention to the difference in perception of 'mental illness' in their country of origin:

'The Somali vocabulary for distress is very limited.' (Somali community worker)

'Depression doesn't exist in our language.' (Somali community leader)

'Stress doesn't exist in Somalia.' (Somali community leader)

Suffering from 'madness' is not recognised as a medical issue but as a moral or spiritual one; when people exhibit bizarre behaviour or thought patterns they are liable to be stigmatised by their families and communities. Carrol's study, 'Expressions of distress in refugees from Somalia' concluded that three words exist in the Somali language 'Murug', 'Waali' and 'Gini', which emerged as expressions of psychological illness for the Somali community.²² 'Murug' has connotations of 'everyday sadness' or 'stress', 'depression' or 'craziness', and can be considered to be related primarily to the migration process and the financial stressors experienced in exile. Symptoms of 'Murug' are wide-ranging, and include 'flashbacks, hair loss, fever or feeling hot, headaches, loss of appetite, poor sleep, crying and a lack of interest in social activity' with some respondents stating that 'Murug' would lead to physical symptoms including diabetes, constipation and high blood pressure.²² 'Waali' was generally meant to be 'crazy' or 'mad', and symptoms can include violent behaviour, taking clothing off in public and 'talking nonsense' and was linked primarily to pre-migration processes including war trauma.²² Carrol also reported that treatment for 'Waali' or 'Murug' usually was accommodated within the extended family and community.²² Finally 'Gini', a particularly 'stigmatising form of mental illness' described sufferers as 'supernatural beings or spirits created by god' and could be caused by 'spirits, ghosts or a curse' and have 'inner voices talking to them'. Religious or spiritual intervention was regarded as the most useful treatment.²²

Although a useful insight with regard to Somali vocabulary and expressions of mental illness, it is necessary to acknowledge the limitations in Carrol's paper. There are other words in the Somali language that are used to describe feelings of distress. For example the word 'Buufis' has meanings associated with 'not feeling normal', and can include depression and anxiety symptoms (Somali community leader), and an SPaRC Somali service user used the Somali word 'Shoog' to describe her mental health symptoms.

The Somali culture does not have 'counselling' in their culture, and consequently it is more common to find emotional safety in the religious or traditional

practice of treating illness as highlighted previously. This often results in the Western mental health model of counselling being viewed as an alien concept, even when it is available in a relevant language. This situation is compounded by the fact that many of the psychiatric treatments available in the UK are rare or unknown, and viewed with mistrust. Furthermore, specific cultural norms and attitudes about sexuality can make it difficult for women to discuss rape and sexual assault with care providers, or to seek mental health treatment. A culturally sensitive approach is therefore necessary if women are to receive the appropriate care. Understanding how these cultural interpretations may impact on potential access and use of Western health care is essential if service providers want to ensure those needing help are getting the help they need.

The challenge of the system: institutional issues

The potential Somali service user is also confronting many hugely vast and complex institutions in the form of the mental health establishment. Bhui and Olajide in *Unanswered questions: a user's perspective in mental health service provision*, are critical of Western psychiatry, particularly in terms of institutional racism.²²

Although not so blatant, racism remains firmly embedded within psychiatry; with its firm adherence to Eurocentric norms, its invalidation of the positive ideologies about life and its problems that come from black world views and the too frequent pathologisation of black expression of emotion, psychiatry continues to perpetuate the myth of the superior Western mind.²³

There is a tendency to respond to problems in line with an established medical model. This can be explained in terms of an imposed 'Western medical model' whereby clinical providers with little understanding of the pre-migratory, migratory and post-migratory experience resort to 'box ticking' in order to provide a recognised and statistically significant diagnosis. Psychiatric theory acknowledges a number of social and environmental factors that are associated with mental ill-health in both a contributory and consequential way. These include poverty, unemployment, poor housing, social isolation and extreme mental stress and trauma.^{3,24,25} However, these are not perceived as the primary causes of the major mental illnesses, rather as secondary contributory factors.

Summerfield and Watters discuss this in more detail,^{26,27} highlighting the potential link between

a narrowing of diagnosis and inappropriate response/service provision: 'The voice of the refugee is only heard within predefined and compartmentalised contexts that conform to and reinforce institutional structures within the health and social care field'.²⁷ Psychiatrists Littlewood and Lipsedge, comment on the level of misunderstanding and misinterpretation, regularly occurring between psychiatrist and patient, leading to situations where substantially more harm than good may arise from treatment.²⁸ This is borne out by outcomes identified in the existent studies as analysed exhaustively by Raleigh.²⁵ This raises the question of whether Western psychiatry is inherently culturally specific, and if so, is not equipped to make judgements on the mental health or illness of people from different cultures.^{3,6,28}

Fernando argues that minority ethnic groups meet with a number of racist attitudes, beliefs and practices within the mental healthcare system, and he argues that these beliefs have become institutional practices which have been implemented over long periods of time.⁸ From the research undertaken, many Somali refugees accessing St Pancras Refugee Centre services find the NHS an incomprehensible system and have little confidence in the role played by primary care workers.

'You always have to wait so long for an appointment. I tell my GP about my foot but he says nothing. I don't know where to go for my foot problem. I am in pain. Some of the bullet is inside. I can't walk particularly in the cold.' (SPaRC service user: bullet wound to foot injury as a result of the war; mobility difficulties, not referred by GP to any services)

Making changes

Mental health services need to take a holistic approach to health, addressing psychosocial issues (see Box 4) and focusing less on individual behavioural change and more on economic, social, environmental and cultural factors. Assistance and advice with practical issues such as housing, immigration, benefits and access to employment and training opportunities can be a crucial supportive intervention when dealing with a group who are dealing with the pressures and anxieties of living in exile.

'The community needs more advice, support and a centre so we can meet.' (Somali community leader)

Mental health services need to promote an inclusive multicultural strategy addressing distinctive cultural

Box 4 Psychosocial disorder

A psychosocial disorder is a mental illness caused or influenced by life experiences, as well as maladjusted cognitive and behavioural processes. Psychosocial refers to the psychological and social factors that influence mental health. Social influences such as cultural and religious background, socio-economic status, homelessness, isolation and lack of immigration status can all help to shape personality and influence psychological makeup.

and linguistic needs. An understanding of social factors, specific cultural understandings and experiences of refugee service users, and an understanding of the migration process is therefore essential in the provision of specialist services. Central to such understanding is the 'refugee themselves'; placing the refugee in such a central position is important in order to provide authenticity, transparency and quality of care.

Recent UK government policies have aimed to shift mental health service ideology from a hierarchical culture to a participative, inclusive and solution-focused approach that seeks to empower users and work in partnership with community and voluntary groups in order to improve mental health services and access.²⁹⁻³² The mental health system needs to work towards challenging systems and institutions that have been accused of inherent racism. The fact of institutional racism is one of the biggest challenges facing Somali refugees and service providers. In both cases the importance of utilising the resources and knowledge of Somali community groups is paramount.

Service providers: making positive and appropriate responses

Providers need to ensure that services engage with refugee communities, community organisations and Somali community groups in order to establish the best and most appropriate approach and delivery of services and, if required, to provide gender-specific services. Research has indicated that the majority of problems faced by individuals within the community were traditionally solved at a kinship level, mainly through traditional models of family and religious support networks.³³ Traditional healers are

also responsible for helping to cure illnesses supposedly caused by spirits; individuals are cured by a healing ceremony, which includes reading the *Koran*, eating special foods, and burning incense.³³ It is important not to impose ethnocentric assumptions to reduce such 'religious practices' in accordance with Western ideologies. Acknowledging the significance of family, religious and community ties is important when considering the development of an approach to the social care needs of this group. It is also, therefore, important to develop outreach programmes in order to share knowledge and help combat stigma and improve access to both community groups and other support networks.

The St Pancras Refugee Centre, in partnership with community members, has responded to the lack of cultural understanding by many health professionals by providing training courses for primary and secondary health providers and community groups, specifically focusing on the needs and cultural context of refugees; this should also be standard practice with other established services to ensure that the needs of the refugee client group are adequately and appropriately met.

Perhaps the initial principal barrier refugees face in accessing any service is that of language. Inability to speak English for the St Pancras Refugee Centre's Somali users is not only problematic during the clinical encounter, but also makes accessing services and appointment making difficult. In response to this, the project adapted a flexible approach to appointments, and this has been highly successful in working with clients who have difficulty in understanding the boundaries and systems in more formal settings. In this way users can access the project at times suitable to them (within some limits based on staffing), and are not strongly penalised for missed appointments. Projects such as the Camden PCT-funded 'Peace of Mind' Somali project responds to linguistic needs by providing language-specific services with interpreters and bilingual counsellors. Although some surgeries and clinics have leaflets in various languages, high illiteracy among the Somali community, and a lack of familiarity with leaflets can negate their effectiveness; a person-to-person approach is therefore essential at the initial stages in service provision.

Responding to the issue of 'trust'

Me and my clan against the world;
Me and my family against my clan;
Me and my brother against my family;
Me against my brother.¹⁰

'I don't trust anyone. No other person, any person, anyone, particularly Somali person.' (SPaRC service user)

Another significant challenge to service providers is their response to the issue of trust. Many Somali refugees have experienced distressing situations specifically with the pre-migration process, resulting in the breakdown in their ability to trust others. This experience is widely spread, particularly among refugees from African communities.¹⁰ The conflicts in Somalia resulted in the break up of communities and family networks; the ability to rely on and trust others was severely compromised. Service providers therefore need to respond in a positive proactive way, working towards the re-establishment of trust, for without it such services will inevitably fail to reach out and respond to the needs of the Somali community. The issue of establishing trust relationships is highlighted in our work within the St Pancras Refugee Centre. The project works towards facilitating a sense of trust and user empowerment. This is obtained by sustained empathy, and a flexible approach with an awareness of an individual's culture. The project has therefore needed to adapt its service provision in order to encourage user involvement; an important part of this flexible, holistic approach is the provision of activities which develop confidence and self-esteem and create a non-threatening space within which clients can begin to develop and rebuild their identity. (The project started a user-led sewing group as a result of a consultation with users. The sewing group acts a 'self-help group' and is an effective response in building self-esteem, while exploring other health issues.) The provision of such generic services is a specific, considered response to the issue of trust and provides an alternative positive pathway into support services and other mental healthcare services.

Conclusion: exploring access and use of Somali community groups in Camden

A review of the effectiveness of partnership work has also shown that initiatives between public, private and community groups have proven to be most beneficial.³⁴ In this way the sharing of experience, information, knowledge and understanding can lead to more appropriate responses to the challenges presented by Somali refugee users in Camden. In the first instance, Somali refugee organisations in Camden have access to interpreters who, with training, are able to advocate for and represent the needs

and desires of the individual refugee within a user participation forum. Secondly, such organisations can be involved in education and training for individuals to allow for independent representations at the service level, and to help develop and support culturally competent services. An inevitable implication for successful Somali refugee service user involvement in Camden would therefore be to ensure effective training in transcultural awareness for mental health professionals and community groups. Such training would need to recognise the importance of health awareness programmes that focus on mental health issues. Somali refugee community group workers in Camden would need specific training so that they were able to recognise the symptoms of mental ill-health and importantly to work with Somali refugees in a supportive environment to combat any negative attitudes and stigma associated with mental illness. In this way community workers would have a better understanding of the specific needs of Somali refugees in Camden, be able to better encourage users to access the appropriate services, and be able to represent their interests with greater confidence and authenticity.³⁵

It has been established from our research that it is most often the case that access and use of secondary services for the Somali community in Camden is virtually non-existent. This paper has highlighted many of the most significant barriers and challenges, including cultural traditions, perceptions of mental health, narrow Western definitions and treatment scenarios, the issue of trust, and the practical implications of language difference. A consequence of these challenges is the necessity to acknowledge the many different potential pathways Somali refugees in Camden may take into the mental health system. Service providers in Camden need to respond to these realities in a flexible and appropriate way. Unfortunately evidence discussed has shown that too often the services provided in traditional state institutions fail to acknowledge the pre- and, in particular, post-migratory experiences, and have a general lack of understanding of the cultural implications involved. This can often result in service providers continuing to label and treat Somali users in terms of narrow prescriptive Western interpretations. The transcultural psychiatry discourse has begun to influence the planning and implementation of policy in this area, but changes are still very much in their infancy, and much work continues to be necessary in the field of refugee service provision. A flexible and culturally appropriate response therefore continues to be essential for voluntary and community groups in order to provide a bridge between Somali users in Camden and traditional established institutions and procedures within the mental health system.

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CONFLICTS OF INTEREST

None.

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