ANTI-TRIBALISM MOVEMENT

IMPROVING MENTAL HEALTH SUPPORT FOR THE UK SOMALI COMMUNITY

A policy briefing

November 2020

ETHNICITY AFFECTS ACCESS, TREATMENT, AND OUTCOMES IN MENTAL HEALTH CARE.

Urgent commitment and resources are needed to improve mental health access, experience, and outcomes for the UK's Somali community. This briefing describes the community's mental health landscape, explores institution-side and community-side impediments to mental health care, and makes recommendations for pathways to change.

I. INEQUALITY AND MENTAL HEALTH

'...an individual from a Black, Asian or minority ethnic background is more likely to experience poverty, to have poorer educational outcomes, to be unemployed, and to come in contact with the criminal justice system. These ... are risk factors for developing a mental illness. These individuals are also less likely to receive care and support when they need it.'

Royal College of Psychiatrists, 2018[1]

The National Collaborating Centre for Mental Health stated in 2019 that ethnicity affects access, treatment, and outcomes that people in the UK can expect to receive for mental health.[2] Attempts to improve equality in mental health provision[3,4] have yielded inconsistent results. Research over the last five decades has 'repeatedly shown that Black Asian and Minority Ethnic (BAME) communities have more adverse experiences and negative outcomes within mental health care compared to the majority population.'[5] The 2005 Delivering Race Equality programme charted an ambitious path to equality, but the independent Mental Health Taskforce to the NHS in England said in 2016 that 'there has been no improvement in race inequalities relating to mental health care since the end of the 5-year Delivering Race Equality programme.'[6] Despite the presence of resources such as *Advancing Mental Health Equality*, BAME people still today describe worse experiences of access to care and treatment, diagnosis and risk assessments, use of the Mental Health Act, length of hospital stays, and quality of care experience, inter alia.[7,8] The *Patients and Carers Race Equality Framework*, now being developed by NHS England and NHS Improvement, could in the coming years have a positive impact.[9]

As the Centre for Mental Health says, 'mental health inequalities are closely linked to wider injustices in society.'[10] BAME communities' adverse experiences of mental health emerge from a number of inter-linked factors:

1. **Socio-economic disadvantage** such as disproportionate poverty and unemployment, low rates of pay, poor educational outcomes, inadequate housing and homelessness, and over-representation in the criminal justice system.[11]

2. **Community factors** including stigmatization of mental ill-health,[12] adverse environment for help-seeking, low trust in mental health services and consequent over-reliance on sometimes sub-optimal healing practices, and gendered responses to mental ill-health.

3. **Institutional factors** including discriminatory processes, structures and attitudes which impact quality, appropriateness, and outcomes of mental health interventions, poor resourcing to deal with diversity in staffing or service provision, inadequate or incomplete understanding of community needs and beliefs, lack of staff confidence or competence to provide culturally sensitive treatment, and unconscious bias.[13]

While it is possible to describe a broad 'BAME experience' of mental health care, a one-size-fits-all approach to designing quality services for BAME communities does not work. Patterns of access, experience and outcomes are specific to individual communities. For instance, Asian patients are about twice as likely, and Black patients nearly four times as likely as white patients to be detained under the Mental Health Act.[14] Rates of recovery following psychological therapies are lower for those of 'Mixed' ethnicity than for those of Black ethnicity, and rates of recovery for Asians is lower than for 'Mixed' or Black people.[15] Not enough is known about the details of ethnicity-based disadvantage as institutions do not systematically record disaggregated data.

This briefing makes visible the mental health experiences of the Somali community in the UK. It identifies institutional and community barriers they face in accessing mental health support, and proposes pathways to positive change. The briefing is based on:

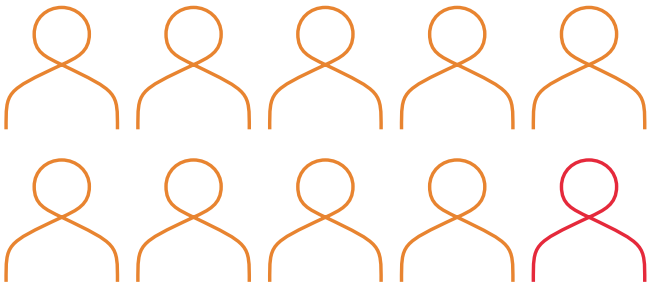
1. a survey with 118 community members in London, Leicester, Manchester, Bristol, Birmingham, and Coventry.[16]

2. interviews with 6 community leaders and experts,[17] for whose time and insights we are deeply grateful.

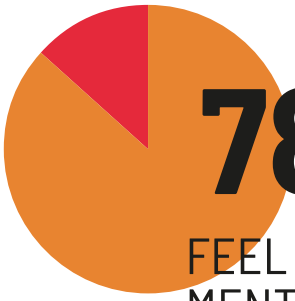
SURVEY FINDINGS

58% of respondents have **felt the need** for mental health support

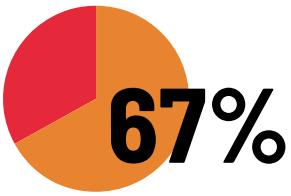
but only 14% **have used** mental health support services



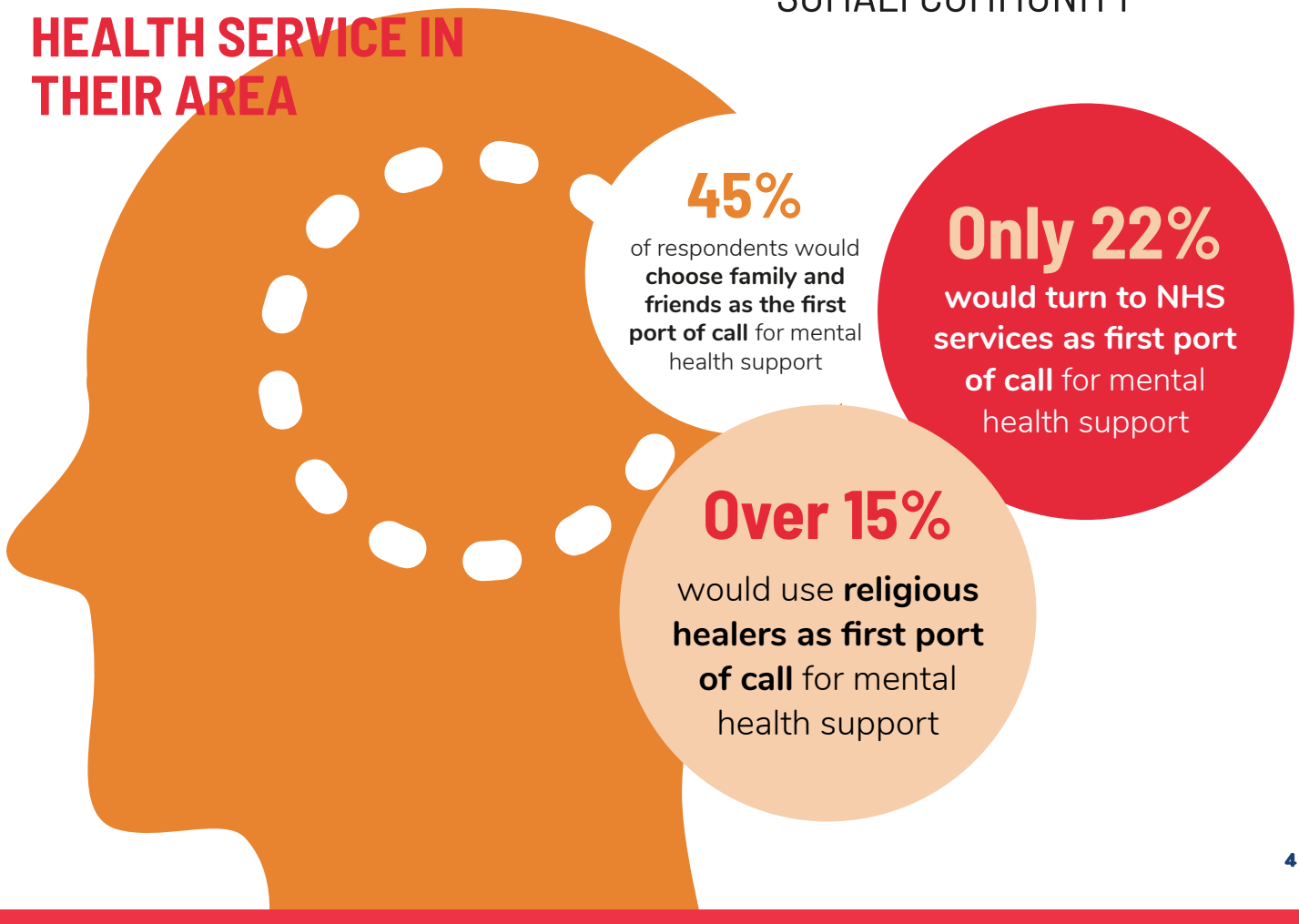
90% WOULD FEEL CONFIDENT TO RECOMMEND MENTAL HEALTH SUPPORT TO FAMILY OR FRIENDS



78% FEEL THAT AVAILABLE MENTAL HEALTH SERVICES **DO NOT UNDERSTAND** THE SOMALI COMMUNITY



67% **ARE NOT AWARE OF EVEN ONE MENTAL HEALTH SERVICE IN THEIR AREA**



45% of respondents would **choose family and friends as the first port of call** for mental health support

Only 22% **would turn to NHS services as first port of call** for mental health support

Over 15% would use **religious healers as first port of call** for mental health support

II. MENTAL HEALTH IN THE SOMALI COMMUNITY

Somali communities in the UK, as globally, have relatively high levels of mental ill-health and low levels of mental health service use.[18] The UK's Somali population is officially estimated at 100,000 but some community estimates put it at around 350,000.

This community faces multiple triggers for mental distress.

- Widespread racism, discrimination, and Islamophobia, coupled with a poor justice-response environment. The prevalence and impact of these cannot be over-stated.[19] Most members of the Somali community suffer racism on a regular basis, resulting in stress, anxiety, fear, powerlessness, and low self-worth which often serves to limit life-chances.
- Disproportionate unemployment and poverty, low financial resilience and high financial stress.
- High rates of school exclusion and poor educational outcomes.
- Overcrowded and poor-quality housing.
- Over-representation in the criminal justice system.
- Under-representation in decision-making roles, arising from and resulting in voicelessness.
- Family separation for recent immigrants.
- Language isolation for non-English speakers.
- Persistent emotional trauma of displacement from and deep longing for Somalia.
- Emerging youth identity crisis[20] - experts are noting increased loneliness, drug use, gang involvement and sexual exploitation amongst young Somalis, and trends towards obesity, bipolar disorder, stress and depression. Linney et al[21] found that Somali parents are suffering mental ill-health from worrying about their children.
- Trauma of the Somali civil war, the effects of which still remain and pass on inter-generationally. In a recent study, 48.1% of Somali refugees met the criteria for Post Traumatic Stress Disorder.[22]

As with other BAME communities, COVID-19 is right now an amplifying distress factor for the Somali community. Many Somali women work in the care industries and are on the frontline of the pandemic. Many Somali men work in the gig economy and face high rates of virus exposure and job insecurity. As Somalis in the UK live disproportionately in over-crowded housing in inter-generational households, they face the added stress of not being able to self-isolate effectively when needed, and not being able to shield elderly and vulnerable family members. There is further the reality of having to deal with the loss of loved ones without being able to support them through their last moments or mourn them properly, and consequent burdens of sadness, anxiety and fear.

1. Prevalence of mental ill-health and help-seeking behaviour

There are strong indications that service provision is not meeting existing need. While 58% of respondents have felt the need for mental health support, only 14% have actually used mental health support. In fact, over 66% of respondents were not aware of even one local mental health service. A community worker felt this was at least in part due to an absence of up-to-date and accessible directories of mental health services. Further, while 90% of respondents said that they would feel confident to recommend mental health services to family or friends who needed it, over half said that the community does not encourage others in the community to seek support. Respondents spoke of barriers within the community which prevented help-seeking, as well barriers within service provision institutions.

A senior mental health practitioner working across London, Birmingham and Leicester said that people in the community often did not seek help before it was too late, and when they did access services, they did not or could not explain their symptoms very well or were in extreme need. She also observed a tendency towards inconsistent healing approaches. For instance, Somali patients who seek treatment through the NHS would, mid-treatment, turn to traditional or religious healers, thus confusing the recovery process. NHS services are currently ill-equipped to understand or integrate traditional healing practices in their treatment and recovery plans.

WHILE 58% OF RESPONDENTS HAVE FELT THE NEED FOR MENTAL HEALTH SUPPORT, ONLY 14% HAVE ACTUALLY USED MENTAL HEALTH SUPPORT

2. Barriers to seeking help

A) Institutional barriers: An overwhelming 75% of respondents felt that available mental health services do not understand the needs of the Somali community. Respondents and experts pointed to the following reasons:

i. Tendency to lump together all BAME communities in terms of mental health needs, resulting in non-appropriate services. As one respondent said, 'Mental health care isn't one size fits all (for all minorities).' An understanding of the specificities of mental health in each BAME community must inform the design of tailored services.

ii. Poor understanding of community needs, access, experience and outcomes due to absence of disaggregated data on Somali service users.

iii. Poor understanding of Somali language and culture, which the majority of respondents identified as a barrier. This leads to cultural contexts being mis- or poorly understood, and therefore inappropriately treated. Issues central to their mental health landscape were alien to mainstream service providers, such as the legacy of conflict, trauma of forced migration and family separation, cultural habits such as chewing *khat*, the 'moral framework in relation to drink and drugs,' and 'Islamic social codes.'

iv. There was concern about poor representation of Somalis in professional roles across the board, not just in the mental health workforce. There are too few Somali voices of authority available to speak positively to promote mental health, in a way that the community can understand and accept.

v. Lack of pro-active engagement by institutions to understand community needs and overcome community barriers. These leads to poor community awareness of services, and therefore poor uptake of services.

vi. Lack of understanding about high-risk groups, such as Somali women suffering domestic violence or youth suffering drug abuse, sexual exploitation, or identity crisis.

vii. A perception that the Somali community does not understand their rights and therefore will not demand them, which results in not being taken seriously.

viii. Top-down approach to delivery, without local understanding of the community. Perhaps because of this, one respondent said, institutions 'don't make us feel comfortable.'

ix. Poor understanding or dismissal of traditional forms of healing used by the Somali community (such as the reading of religious texts). As one respondent said, 'If there were therapists who mixed both Islamic help (and mainstream therapy) and understood the culture, it would definitely help.'

Our expert interviews highlighted a plethora of other systemic failings. Delays to offer help led to worsening of mental health, significantly impacting on carers' mental health. Practitioners' are disinclined to find effective ways to communicate with Somali patients. Somali people are disproportionately subjected to involuntary detention, leading to fear and erosion of trust. There is fear (particularly amongst women) that disclosure of mental ill-health would lead to children being taken away by social services. Experts we interviewed were critical of outreach attempts that were little more than leaflet drops. They wanted institutions to stop using the notion of Somalis being a 'hard to reach' or 'resilient' community as 'excuses to do nothing.'

B) Community barriers: When asked about the barriers in relation to accessing mental health support, almost 75% of respondents described barriers within the community. These include:

i. Stigma and ostracization of people in mental distress, and taboos about the subject. These were mentioned by over 66% of the respondents.

ii. Poor understanding of mental ill-health and its signs, or the perception of evil spirits or 'djinns' as the cause.

iii. An expectation that people in mental distress should 'man up', or 'pull themselves together and carry on.'

iv. Shyness and embarrassment, and sometimes unhelpful concealment. One respondent said, 'we don't … give full information about what we need. We are evasive.'

v. Lack of trust in institutions, stemming partly from past bad experience and systemic discrimination, and the fact, as one respondent put it, that 'mental health services do not have enough familiar faces, eg Somali professionals you can relate to and understand.'

vi. Inability to afford private therapy.

vii. Fear of mental health medication.

viii. Lack of confidentiality. One respondent said, 'It becomes headline news amongst the community if (someone) is using mental health services, this is why people tend to not seek help.'

Experts commented on the need for counter-narratives to show the positive side of seeking help for mental distress. They feel the prevalent negative narratives put people off help-seeking. They also worried about community practices such as taking people with mental ill-health to Somalia for traditional treatment, or getting them married in the hope that would solve the issue.

'...health inequalities that could be avoided by reasonable means are unfair.

Putting them right is a matter of social justice.'

The Marmot Review [23]

III. POLICY RECOMMENDATIONS

Based on our knowledge of the Somali community, insights from our recent community survey, and interviews with community leaders and experts, we offer targeted suggestions for key stakeholders. One set of recommendations is for the **Department of Health and Social Care**, and **NHS England and NHS Improvement**. Another is for **statutory service providers and commissioners** and the Sustainability and Transformation Partnerships and Integrated Care Systems they work within. The third set of recommendations is for **community groups and voluntary sector organisations** that work with the Somali community. Though these recommendations are specifically to improve the mental health environment, care access, experience and outcomes for the Somali community, they will also have relevance for other BAME groups.

1. Department of Health and Social Care, and NHS England and NHS Improvement

We believe DHSC, and NHS England and NHS Improvement should:

i. Build an equality-friendly mental health environment

a. Institutions must understand the specificities of mental health in diverse BAME communities, and tailor services based on this understanding.

b. Use effective incentives, levers, and resources to encourage and support Sustainability and Transformation Partnerships and Integrated Care Systems (and service providers and commissioners working within them) to prioritise community-led and community-oriented approaches to mental health and well-being.

c. Promote integrated working between stakeholders who have influence over mental health determinants and care for Somali communities, eg. health services, therapeutic services, schools, social services, youth services, employment services, and criminal justice agencies. Such integrated systemic approaches should identify and address root causes of mental ill-health in the Somali community, and work towards early identification and appropriate support for those in need.

d. Prioritise collection and use of disaggregated data by service providers and commissioners to understand inequalities in access, experience and outcomes, including in areas of particular concern to the community such as disproportionate rates of detention. This should lead to evidence-based policy-making and community-relevant interventions.

e. Improve recruitment of mental health workers from within the Somali community, where a trained pool of professionals is fast forming.

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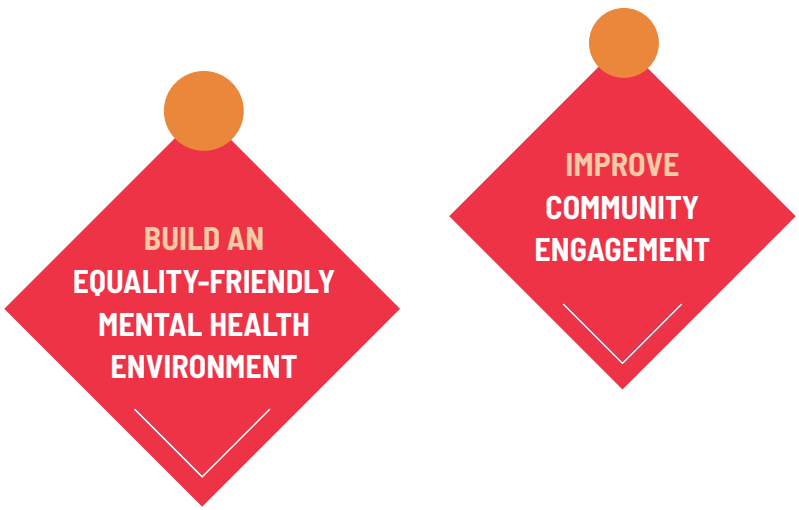
ii. Improve community engagement

a. Bring Somali voices into strategic and policy-making fora to embed the community perspective. Many Somali community organisations stand ready to participate and contribute.

b. Recognize that community voice is diverse – the inter-sectionality of mental health experience must be acknowledged by including all sections of the Somali community.

c. Offer learning opportunities for the Somali community about mental health and well-being, referral pathways, and consultation/ dialogue mechanisms.

d. Rethink communication channels by which data and messaging is shared with communities. Increase the use of community channels, Somali media, and social media.



2. Statutory service providers and commissioners (under the leadership of Sustainability and Transformation Partnerships - STPs - and Integrated Care Systems - ICSs)

We believe statutory service providers and commissioners should:

i. Prioritise equality of access, experience, and outcomes

a. Make more consistent and meaningful use of existing guidelines and equality assessment frameworks to find pathways to inclusion.[24]

b. Put resources and commitment behind improving mental health service provision for Somali communities, most particularly in STPs and ICSs which serve a significant Somali population.

ii. Build knowledge and relationships

a. In STPs and ICS's serving Somali populations, engage Somali stakeholders with lived experience of mental ill-health at every possible stage of the commissioning cycle. Involve them to build cultural competencies in staff, engage them in accountability and governance mechanisms and service design. This will simultaneously help build relationships and trust with the community.

b. Collect and use disaggregated data to understand mental health needs of the Somali community, and to identify inequalities in access, experience and outcomes. This knowledge should directly inform how services are designed and delivered.

c. Improve practitioners' understanding of help-seeking behaviours in the Somali community.

d. Find ways to integrate diverse approaches to achieving good mental health, including alternative forms of healing used by communities (where possible and safe).

e. Explore with relevant partners whether community perceptions of disproportionate targeting for negative treatment (such as involuntary detention, and taking children into care) have a basis in reality. If so, they need to be urgently addressed. If not, then these myths must be busted and trust rebuilt.

iii. Improve outreach and access

a. Undertake pro-active community engagement, and be a positive presence in the community. Take services and information to the community rather than waiting for the community to come to the services.

b. Provide opportunities for mental health workers at all levels to engage with the Somali community in non-clinical settings – where they are not focused on treating, but on learning about the community. Somali community organisations are willing and able to facilitate such opportunities.

c. Improve and expand referral pathways into mental health services – the current over-reliance on GP referral service is not working effectively for the Somali community.

d. Make efforts to increase the number of Somali practitioners; meantime, expand the pool and skills of Somali-speaking interpreters.

e. Ensure that the Somali community has access to regularly updated information on available private and statutory mental health services.

3. Community groups and voluntary sector organisations

We believe community groups and voluntary sector organisations should:

i. Break down stigma

a. Create positive narratives around seeking support for mental health, highlighting the courage and wisdom in seeking and getting help, showcasing how this can present opportunities to thrive.

b. Challenge community stigma and shame around mental health and help-seeking.

ii. Build knowledge

a. Train community members and leaders to understand mental health and mental distress, structures and systems of mental health services, and ways of supporting/ referring people in need.

b. Be alert to emerging patterns in community mental health, and engage appropriate voluntary and statutory fora for early action.

iii. Build coalitions

a. Forge alliances across communities to identify and amplify shared advocacy asks.

b. Target decision-makers collaboratively, with clear and consistent advocacy messages.

c. Pro-actively engage service providers and commissioners in order to influence policy and practice for the good of the community.

iv. Seek improved representation

a. Promote mental health careers to people in the community.

b. Engage actively in mental health consultations and advisory bodies – a current opportunity exists in on-going consultations towards the development of a *Patients and Carers Race Equality Framework* for mental health services (see Reference 9).

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