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Research paper

Caught between inequality and stigma: the impact of psychosocial factors and stigma on the mental health of Somali forced migrants in the London Borough of Camden

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ABSTRACT

This study was established to assess the impact that psychosocial factors have on the mental health of Somali refugees and how Somali people's perception of mental illness impacts on both community engagement and on accessing and utilising services. Information on service utilisation was drawn from secondary sources and data about users of a refugee centre in London. In addition, semi-structured interviews were conducted with a sample of Somali forced migrants accessing the refugee service. The results indicate that the mental health of Somali refugees in Camden is shaped by social factors which characterise exile, and that access to health services is compounded by a preoccupation with post-migration stressors including immigration status, housing, social and socio-economic factors. In addition, Somali forced migrants make considerably less use of community groups due to stigma, which hinders the building of social capital for their members. This research adds to the knowledge base about good practice and service delivery.

Keywords: mental health, psychosocial, refugee community groups, refugees, social capital, Somali

Introduction

Studies of the mental health needs of forced migrants revealed that they are disadvantaged when compared to native populations and voluntary migrants in terms of their mental health experience and levels of exclusion (Burnett and Peel, 2001a,b; Tribe, 2002, Box 1). This paper is concerned with the specific mental health and social care needs of Somali forced migrants within a determined geographical area: Camden, London, UK. It begins with a review of the literature about mental health and culture and then presents a research study that focused on one particular service provider, the St Pancras Refugee Centre (SPaRC) (see Box 2). The complexity of the issues experienced by those living in exile and how mental health perception and stigma impact on community participation are discussed, and the paper closes with reflection on the future for Somali refugee groups and the need for a more integrated and holistic approach in the planning and delivery of services by various stakeholders.

Box 1 Mental illness

The term *mental illness* is used here as a general term for a group of illnesses. A mental illness can be mild or severe, temporary or prolonged, and can come and go in episodes throughout a person's life. Some experience their illness only once and fully recover. For others, it is prolonged and recurs over some time (Palmer and Ward 2006).

Box 2 The St Pancras Refugee Centre

The St Pancras Refugee Centre (SPaRC), one of three projects based within the Holy Cross Centre Trust, is a 'one stop shop' based in Camden, London and aims to facilitate the social integration and improve the quality of life of forced migrants, with a particular focus on their mental and physical health issues. At the time of this research, the project offered a 'holistic' response to the needs of refugees, providing advice and advocacy, social and emotional support, and access to health services, education and training. This project therefore provided a good source of information for this research.

The mental health of refugees: cultural and psychosocial factors

Forced migrants are not a homogeneous group, they vary in nationality, ethnicity, social and cultural background, and consequently differ in how they express their needs (Bhugra and Bahl, 1999). The disadvantages refugees experience are multifaceted, being influenced both by the pre- and post-migratory experience, specifically the post-migratory socio-demographic variables including the wider experiences of unemployment, housing problems, poverty, poor health, difficulties in accessing services, discrimination and hostility (Summerfield, 2001a,b; Watters, 2001). Although refugee and indigenous populations have 'common multiple risk factors for mental health problems' (Warfa and Bhui, 2003, p.26), including housing and/or income issues, the mental health of refugees will also differ from that of the indigenous population for a number of culturally specific reasons.

The cultural contexts in which people live influence the way they define and experience mental health and mental illness. Cultural factors can influence whether people seek care for their symptoms, what kinds of care they seek, and where they seek it including primary care providers, mental health providers, traditional healers or family members (Helman, 2000). Cultural factors can also influence how symptoms are reported as people express them in culturally based ways (Fernando, 2002). Refugee communities are diverse, and each group has its own language, history, cultural norms and religious beliefs as well as perceptions of health and illness. However, exchanges among refugee community groups can help build bonds through shared experiences. Such exchanges can also help those involved in healthcare provision to learn about and value different skills, languages and cultures, thereby enriching the larger community, and increasing *social capital*. The concept of *social capital* is an important feature of social environments, and there is growing evidence that communities with a good 'stock' of *social capital* are more likely to benefit from better health (Pearce and Smith, 2003). *Social capital* consists of the 'stock of active connections among people: the trust, mutual understanding, and shared values and behaviours that bind the members of human networks and communities and make cooperative action possible' (Cohen and Prusak, 2001, p.4). *Social capital* is thought to mediate against the downward social drift caused by mental illness and to reduce the impact of the psychosocial stressors experienced by members of vulnerable groups in socially disadvantaged situations. *Social capital* is also believed to influence the health of individuals by providing effective support and acting as a source of self-esteem and mutual respect (Wilkinson, 1996). Refugee community groups therefore have a vital role in leading and promoting change based on the truly representative views, needs and experiences of refugee service users. As a result, when examining the mental health needs of refugees it is important to consider refugee community engagement and *social capital* as a prerequisite for effective policy and successful policy implementation.

Literature: settlement and mental health issues

With a few exceptions, research on the Somali community is contained in small, local studies often carried out by local authorities, voluntary and community groups, which are not distributed widely and are difficult to obtain (Harris 2004). A study into the housing experiences of England's Somali population undertaken by researchers from Sheffield Hallam University's Centre for Regional Economic and Social Research reveals a worrying picture of 'a hidden society ... [where] extreme levels of deprivation and disadvantage are commonplace' (Cole and Robinson, 2003, p.31). The report's findings are based on five urban case studies of Somali populations in London (Tower Hamlets and Ealing) and the cities of Liverpool, Bristol and Sheffield, using existing data sources, literature and research evidence, input from local authority officers, Somali community group leaders and focus group sessions with key subgroups of the population. In each case, the Somali communities' problems were being further compounded by the failure of agencies to understand their specific needs. One of the central conclusions made in the report is the need for funding for housing specifically targeted to meet the needs of the Somali community (Cole and Robinson, 2003).

The experiences of Somali residents in Camden appear to be comparable to those of residents in other London boroughs.

A study by McCrone *et al* (2005) highlights the prevalence of mental illness among Somalis living in London, with issues ranging from stress and anxiety to suicide. The same study reported that although this community had a high level of needs, the numbers accessing services were low (McCrone *et al*, 2005). In a study of elderly Somalis in London in 1995, older people were found to have a higher prevalence of depression when compared with white groups of a similar age; 99% of respondents reported low life satisfaction scores, with 24% indicating a high probability of clinical depression and 21% reporting suicidal thoughts (Silveira and Ebrahim, 1998). A 2003 UK study of a random sample of 180 Somalis in the London Borough of Greenwich found increased depression with each identifiable pre-migration traumatic event, and increased depression with a higher total trauma score. This study explored suicidal thoughts, and found factors that correlated with increased suicidal thoughts included over seven years of residence post-migration, pre-migration unemployment and recent arrival (Bhui *et al*, 2003). High incidence of depression, social isolation, low level of control over one's life, helplessness and social degradation were common themes identified in people said to be depressed (Bhui *et al*, 2003).

Demographic data about refugees in Camden

Approximately 210 700 people live in the Borough (Camden PCT, www.camdenpct.nhs.uk). Estimating the numbers of refugees in this or any other specific location in the UK is extremely difficult due to the transient nature of resettlement programmes and the non-specific categorisation of ethnic groups in census statistics. The most recent estimates to be found in Camden Council literature are 20 000–25 000, or 10–13%, of the borough's total population, of whom 16 000 are thought to be of working age (Camden PCT, www.camdenpct.nhs.uk). The 2001 census recorded country of birth, but ethnic categories were geared to established minorities. Thus, all the substantial refugee groups in Camden are recorded variously as 'Black African' (Somali, Ethiopian, Eritrean, Congolese), 'Asian Other' (Iraqi, Iranian, Kurdish, Azerbaijani) or 'White Other' (Bosnian, Kosovan, Russian, Colombian; London Borough of Camden, 2003a,b) 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 (Khan and Jones, 2003). However, the number of refugees living in highly temporary or unofficial accommodation is high, including many who lodge with family or friends, and this, in conjunction with language problems, is likely to lead to census figures being substantially underestimated (Khan and Jones, 2003). There are a few statutory mental health services specifically targeted at refugees in the area, identified in Ward and Palmer's (2005) mapping of mental health provision for refugees in London. However, there is also a general lack of awareness amongst health providers in the area of the distinct needs of this group, which are multiple and complex and require specialist knowledge (Box 3).

Box 3

The Index for Multiple Deprivation (IMD) provides an all deprivation score for local authorities and incorporates factors such as income, employment, health and disability, education, housing, living environment and crime www.communities.gov.uk. According to the IMD, Camden is the 19th most deprived local authority of the 364 in England and the most polarized in London (London Borough of Camden, 2004). The Standardised Mortality Ratio in South Camden is 60% higher than the national figure. 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 (London Borough of Camden, 2004).

Methodology

This research was intended to examine the mental health and social care needs of Somali refugees using the St Pancras Refugee Centre in London (SPaRC, see Box 2). Ethical clearance for this study was received from the University of Kent's ethics committee, and the research was approved by the trustees of the Holy Cross Centre Trust, which included academic researchers, stakeholders from statutory and non-statutory organisations and a Somali national (see Box 2). A multi-method approach was adopted to facilitate the collection of both quantitative and qualitative data drawn from literature, project statistics (SPaRC), project users, and Somali community groups in the London Borough of Camden. According to Fontana and Frey (1998), the benefits of a multi-method approach are that it allows for greater depth and rigor in investigations, and the results obtained are broader and, in their opinion, better.

Limitations of the study

It is necessary to acknowledge the limitations of this study. A total of nine interviews were undertaken between January and April 2006 and it could be contended that the information gained from such a small sample cannot be generalised to a wider population of asylum seekers and refugees (Jacobsen and Landau, 2003). However, analysing the specificity of different individuals is seen as significant, especially for the Somali community, and the views and opinions will allow for some level of exploration of the impact of social factors on mental health for the wider forced migrant population (Hollway, 1989).

Statistical analysis

A part of this research involved the analysis of official documents and a database relating to users of the SPaRC. The information was analysed manually. This method was used to summarise information and provide demographic details allowing for the development of a rounded picture of those using the project, and enhancing the context of the research. The project statistics were published in the *International Journal of Migration, Health and Social Care* as part of an article on refugee mental health provision in Camden (Palmer, 2006).

Qualitative study

Sampling: maximum variation sampling and issues of re-traumatisation

All service users for this research were recruited through existing contacts at the SPaRC. At the time of the research, the centre provided advice and support, mainly on housing, welfare, health and social care issues, to forced migrants from a range of backgrounds. The centre was chosen for reasons of access and because the author, as the researcher, was a previous employee and therefore had a relationship with the staff and some of the clients at the project. This was considered important in ensuring that the research was carried out in a trusting and collaborative manner.

Maximum variation sampling was used when identifying potential interviewees (Patton, 1990). This technique enabled the purposeful selection of a set of individuals who exhibited maximal differences in terms of creed, current location in Camden, London, age and immigration status. A balance between male and female interviewees was also sought. While maximum variation sampling does not allow an in-depth exploration of issues affecting a particular client group, with common backgrounds, it does serve to identify important common patterns that cut across variations.

Exclusion criteria were also applied when considering potential interviewees. The vulnerability of individual service users, their capacity to provide informed consent and the possibility that an interview might result in 're-traumatisation' were issues discussed with project staff before a decision was made on whether or not an individual was approached. Where there was doubt about the possible negative affects of an interview, the individual in question was not approached.

Interviews and data collection: issues of complexity, accuracy and trust

The majority of data were collected through in-depth semi-structured interviews. There is much debate about different types of interview: *formal, informal, structured, semi-structured* and *unstructured* (Denzin and Lincoln, 1994; Burgess, 1995). Semi-structured interviews are distinct in their approach, format and the type of information they elicit. The informant is allowed and encouraged to give lengthy and considered responses, and this type of interview may take place in a variety of situations (Hammersley and Atkinson, 1995). Semi-structured interviews were appropriate for this project because of the complex and sensitive nature of the topic. This particular method is referred to by Omidian (2000) as 'irreplaceable' for researching psychosocial issues with refugees (Omidian, 2000, p.49). Some of the interviews required respondents to give retrospective interpretations, and for this reason issues associated with accuracy had to be considered. The adoption of a qualitative methodology and the use of semi-structured interviews allowed cross-checking so that inconsistencies in recall could be identified and probed (Jick, 1983). In addition, given the care that had to be taken to put these respondents at ease, a semi-structured approach was considered more likely to gain the informant's trust and elicit information than a formal, interrogative approach. Consistency was ensured by using a detailed question guide with a number of prompts and probes. The design of the guide was informed by literature on the provision of mental health services for refugees and asylum seekers, and by previous research undertaken by the author (Palmer and Ward, 2006).

Cultural and language considerations

Approaches to and understandings of mental health inevitably vary between cultures and at different times throughout history. A consequence of this reality is that while undertaking research, behaviours can be interpreted in different ways, and subsequent findings will vary in accordance with the dominant understandings and practices. In the design and development stage of the questions, phrasing was discussed at length with lecturers from the University of Kent and staff at the refugee project, to ensure validity and reliability in the context of cross-cultural research.

The topic guide was extended by a number of prompts and probes to ensure greater interviewee–interviewer consistency. A number of demographic and contextual questions were also included in the questionnaires in order to enhance the developing understandings. The words of the respondents are presented here in an anonymised form.

Five of the interviews with service users were carried out using an interpreter. Language can be a significant barrier to research and 'involved more than just a literal transfer of information' (Temple and Moran, 2006, p.40). In cases where there was no shared language, trained interpreters from the Manor Garden Advocacy Project, who were known to the project, were recruited. In selecting translators for this research, priority was given to those with considerable translating experience.

The qualitative data were analysed manually and a thematic approach according to the principles of the framework method was applied (Ritchie and Spencer, 1993).

Ethical considerations: the role of the researcher – insider or outsider?

A major ethical consideration for this study was the researcher's 'outside' status as a professional previously involved in the refugee project (SPaRC). The intention was to take an emic approach that allowed the service users' views and experiences to be heard (see Box 4). The 'development model' in which refugees are employed as co-researchers on the basis that 'as insiders their knowledge is superior' was considered (Temple and Moran, 2006, p.11). Temple and Moran (2006) argue some of the limitations of this model and highlight work by Twine (2000), which states that 'insider' status can generate its own *bias*. It was, therefore, essential to address this potentially problematic situation in my own research while also acknowledging the critique of the development model.

Box 4 The emic approach

The emic approach is the 'insider' perspective, in which the world-view of the people who are ill or distressed is adopted. The cultural and social system in which the people find themselves is seen as central to understanding the illness (Berry *et al*, 1992).

As the researcher, I was aware of my position as an 'outsider'. Although I am from a minority ethnic group and a first-generation migrant, I am not a forced migrant. I was also fully aware of the implications that my status as a previous project manager might entail. As a result, I had great concerns that the uneven power relationship between the researcher and the researched would be exacerbated by the fact that the interviewees might also be previous clients of mine. I needed to remain conscious of my position as the researcher and how this could affect the feelings and responses of respondents (Brown and Lloyd, 2002). I aimed to foster the agency of the refugees and let them contribute to the research methodology. It was, therefore, important to allow respondents to decide where interviews took place, allowing them some authority and control over proceedings.

No research is disinterested, and I recognised that my own priorities would undoubtedly influence my research. However, I was careful to locate myself in terms of my own interests, position and concerns, but without attempting to influence the content or course of the conversation. I, as researcher, also addressed this by ensuring that service users were given detailed information on the study and plenty of time to think about their involvement. They were also informed that their participation, or non-participation, would in no way affect the services that they were receiving from the centre. Clients identified as particularly vulnerable or dependent, by any of the staff at the centre, were not approached. The fact that some potential interviewees declined when approached suggests that the invitation to participate was not felt to be coercive.

Another important factor was to provide an environment within which the respondents felt able to talk without feeling restricted by time or because they felt they were being judged in some way. I adopted an informal approach and emphasised that whatever they said would remain confidential. I also made it clear that interviewees could withdraw at any stage. In addition, some agreed to take part in an interview but then cancelled the appointment or simply did not attend. This again suggests that the interviewees did not feel coerced into participating. Although I had wanted to follow up non-participation in order to be better informed, unfortunately due to time constraints, I was unable to achieve this.

Findings

Demographic statistics

A total of nine Somali users participated in this research, five female and four male. The mean age was 32 years, with ages ranging from 18 years to 62 years. All participants lived in the Borough of Camden. Two were in permanent council rented accommodation, two were residing with friends, one was street homeless and four were in temporary accommodation. All participants were unemployed and seven were

in receipt of welfare benefits which included Income Support and Disability Living Allowance, one was without any form of National Asylum Support Service (NASS) or subsistence support, and one was in receipt of NASS subsistence support. Education and English language ability levels varied. All participants reported that they were living as single people in the UK, but five were married with their spouses either living elsewhere, deceased or 'missing'. One had separated. All participants were first-generation forced migrants. One of those interviewed was an asylum seeker, one had had an application for asylum refused on appeal, one had Exceptional Leave to Remain (see Box 5), one had British citizenship and the rest had been awarded refugee status. Four of the users (male = 2; female = 2) had a mental health diagnosis. At the time of the interviews, three were accessing mental health services provided by the NHS; none were using counselling provided by a refugee community organisation (RCO); six were not accessing any mental health services.

Box 5 Exceptional Leave to Remain (ELR)

Until April 2003 applicants whose circumstances did not merit a grant of asylum under the Refugee Convention, but whom the Home Office felt should be given leave to remain in the UK on humanitarian grounds or compassionate grounds, were granted 'exceptional leave to remain'.

Analysis of the interviews yielded a number of themes, each of which is presented and discussed below.

Mental health symptoms and difficulties encountered

All participants reported experiencing some form of mental distress, and symptoms included having constant 'nightmares, feeling stress, being angry, alone and panicky and mad'. Medical diagnoses, for those who had them, included depression, anxiety, psychosis and post-traumatic stress disorder. Participants indicated difficulties with a number of social and economic issues. Everyone had problems with housing at some stage, which included overcrowding, homelessness, inadequate temporary accommodation, poor location, noisy neighbours, lack of privacy and having to share facilities with non-family members. Housing status was clearly linked to requirements for a good quality of life. Two of the interviewees stated that they had experienced problems with immigration. One had been threatened with deportation, and four reported having had problems with benefits or with finding enough money to live on. Three people indicated that they felt very isolated, and four stated that they missed family members. One individual highlighted barriers to finding employment as an issue. Difficulties relating to racism, language, family and community conflict were all cited at least once.

Mental health and trauma

All participants recalled a lot of traumatic experiences in Somalia as contributing factors to the current state of their mental ill health. Feelings of social isolation and loneliness were reported, primarily due to family separation. Flashbacks, nightmares, concentration difficulties and headaches and feelings 'of being lost' were common complaints:

> 'I saw many many people killed and raped in Somalia. I have depression [shoog]. Sometimes I scream in the middle of the street. I shout, I spit and I get angry at people in the street. It comes from inside. I don't want to remember about it, I don't want to talk to people about it. Sometimes I go outside without shoes on and I forget until I feel the cold on my feet. I don't want to speak to Somali people about it. It's because of Somali people that I am sick.' (Somali female)

Reference was made to beatings, rape, imprisonment, torture and witnessing brutality and killings:

> 'I think about Somalia, we grew up in a lot of problems, killing people it was genocide. Coming in at midnight to homes and killing 40–60 men. You always remember, you always think about it. It stays with me always.' (Somali male)

The high suicide rates amongst the Somali community in Camden were also highlighted:

> '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.' (Somali male)

Difficulties in exile

Psychosocial issues and mental ill health

All participants reported that factors such as housing, poverty and adverse social circumstances played a major role in their mental health problems. Poor housing was cited as one of the biggest difficulties and an immediate stressor. Everyone felt that deprivation and the lack of adequate housing impacted negatively on their mental health:

> 'I have a big big problem with housing and status. I need to 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 all the way around. I have pains in my foot from the bullets. I am tired. I don't have housing and money. Not many could live like me. I am out of humanity. I am rejected. What am I? One of the human people but I am out of humanity and rejected here.' (Somali male)

'I was experiencing stress here. The stress was because I didn't have a place to stay or support. I was feeling to kill myself. I was sleeping in the streets. I was sick, very sick with TB. I didn't have support. I was crying, crying, thinking all the time, headaches and couldn't sleep. I would get lost and frightened.' (Somali male)

The insecurity and disruption of living in temporary accommodation, often in cramped conditions, clearly seemed to have a damaging effect on well-being:

'I have lived in hotel in King's Cross for three years. It's bad, really bad, people steal your food, drink much, get angry with lots of fighting at night. The shower is broken and the hotel place dirty. People always smoking. You can't have friends. I went to the manager but he didn't listen. I asked to move and they want to give me place outside. I don't know people there. I have TB, I am sick and need help with thing.' (Somali female)

The existence of psychosocial factors as contributory to mental health was evident in all the interviews. A number of participants specifically pointed to the difficulties associated with the insecurity of temporary accommodation and the constant threat of being moved to a different area:

'You become settled and then the housing want to move you to Enfield or somewhere. The housing system is the worst problem. Going from place to place, I need a settled place, I am always thinking about it.' (Somali female)

The majority of participants reported wanting to stay in the area. Housing preferences were shaped by familiarity with the area, known support networks and language support:

'I know King's Cross. We have the centre [SPaRC], friends, English class and GP [general practitioner] and help with translation. I'm happy to stay.' (Somali female)

One respondent reported refusing to go outside the borough area. Conversely the desperation to move out of temporary accommodation resulted in one person being willing to move anywhere as long as it resulted in a permanent settlement.

The asylum-immigration process

The immigration system and the complexity and great uncertainty surrounding the immigrants' legal status were other problems. Persistent anxiety over the possibility of being detained and/or being deported, and the need to deal with the complex legislation and decision-making process, had resulted in an increased level of anxiety and distress and demoralisation for many of those interviewed. Two interviewees believed that the issue of suicide within their communities was directly linked to the stress and desperation felt when dealing with the immigration authorities:

'The first two refusals from the Home Office caused big problems. I was not able to sleep. I know many people from Somalia that have stress. I know one lady who got refused three times and then one day she became like mad. She jumped from a very high building and died. This was in Glasgow. I knew her from Somalia. We were in contact.' (Somali male)

Other social issues were identified by four of the interviewees and included financial difficulties, inability to find work, studying and welfare benefits issues. In addition, the gap between people's expectations about the UK and what they actually experienced once they arrived was highlighted as a reason for depression and stress:

'Here they think things will be easier but then you can't find job or money or housing, study, national insurance number and there are all these problems that they didn't know about. You lose hope and this causes depression.' (Somali male)

'The system is narrow, if you don't fit exactly you don't get help.' (Somali male)

Conceptions of mental health

Another issue that emerged during the interviews was the difference between the western understanding of mental health and the way in which mental health is understood in Somalia. The health of and issues of accessibility for Somali refugees can be underpinned by culturally specific understandings of mental health, stigmatisation of mental health issues and the method of treating illnesses. Eight interviewees observed that the concept of stress or depression did not exist in their country of origin and that, according to their culture, mental health had associations with madness in that individuals were seen to be either mad or sane. This polarisation could act as a barrier to accessing the necessary support.

'Inside Somalia people are crazy but they don't have depression. They [Somali community] didn't know about depression ... I didn't want to publicise. Depression doesn't mean anything in Somalia.' (Somali male)

'In Somalia people have problems and have stress but there is no record or investigation because there are no doctors out there. The whole country has been stressed for 14 years. People from Somalia use a different language about stress. When I came here I learnt the word stress because it is not well known in my country. Somalian people who are having stress thinks that he is okay but other people see that he is not. Educated people know that they have a problem but people who are not, don't. If someone is stressed they say ''Waa waa she'', which means mad. It is quite extreme, there is nothing in between. Stress is less than mad but Somalians talk about being mad.' (Somali male)

Barriers: issues of confidentiality and stigma

All participants expressed concerns around confidentiality and the negative impact their condition might

have if it were known within the community. The majority reported that mental health issues were stigmatised. Individuals reported finding themselves facing a constant series of rejections and exclusions from the community, and so would be reluctant to define themselves as having any mental health problems. The most damaging effects of stigma were the inability to engage with the community, their unwillingness to seek help there and the subsequent impact on access to healthcare and language and other forms of support:

> 'No, no they make signs. They say people are mad. People speak. Keep away from that. They want a history. They just like talk.' (Somali male)

> 'I don't go to the Somali centre because everyone knows you and all the people talk. They will talk about your problems.' (Somali female)

> 'I don't trust any of those groups. They say that ''this man is crazy''. Somalis talk too much.' (Somali male)

> 'People in the community do not want to be with you if you are mad.' (Somali male)

What helps?

Practical help

Participants were asked what made them feel less distressed or improved their well-being. Several different factors were cited. Everyone identified the need for practical solutions, with particular references to housing and income. Three people stated that medication helped them to feel better, socialising and keeping busy were also identified. Praying (two people), attending English for speakers of other languages (ESOL) classes, art and music groups, sport, and user-led groups such as sewing (two people) were also highlighted as useful coping strategies:

> 'When you get good things, accommodation, you have comfort.' (Somali female)

> 'It's Allah who decides. He knows everything and what has happened and what inside. Only he knows and will decide what happens.' (Somali female)

The support of community groups

Participants reported increased isolation, loneliness and disengagement from their community following the diagnosis of their mental health problems. Only three reported that they were in contact with their community groups for practical help or to socialise. The individuals who were not in contact with their community indicated that this was because they did not find the community group helpful or they did not like mixing with people from their country because of stigma or a lack of trust. Three also observed that people in their communities had their own problems and didn't have the capacity to help them:

> 'Every Somali has a problem. No one is able to get help from Somali people. Everyone speaks about their own problems and I feel worse.' (Somali male)

> 'The community can help one or two times but they can't do more than that. The UK is a very developed country so people are thinking: ''why aren't the government helping?''' (Somali male)

The efficacy of therapies

Those accessing mental health services had diverging opinions on the efficacy of talking therapies. One participant found talking therapy to be very beneficial; others were sceptical about how effective just talk was in helping their situation:

> 'I think always about my children. I have headaches, nightmares and stomach pains, talk will not help. I want help with real issues like finding housing and getting my children over from Kenya. Why should I talk about problems? I don't want to remember, I want to forget.' (Somali female)

> 'What use is talking? It is a waste of time. You need to forget. The Koran, that's the duty.' (Somali female)

Thinking differently: suggestions for improvements

Participants were asked what else could be done to help Somali people experiencing emotional distress. The most common suggestion was the creation of more housing centres offering advice and help with finding permanent accommodation. Great importance was attached to the need for generic or holistic centres offering advice and advocacy on a range of issues such as asylum and immigration, health and welfare. It was also suggested that these centres could offer support and development opportunities, such as training and language support and help with official forms.

Two participants stated that there should be more services on offer such as art, music, sewing and language groups to help them develop skills and socialise. Two people also felt that they benefited from services that provided relaxation opportunities and techniques such as Indian head massage and complementary therapies (see Box 5). Finally, one person observed that there needed to be more education about UK culture in his community and the meaning of stress, and assistance with perception within the Somali community:

> 'Most Somalis don't understand what is going on in Britain. They get the Home Office paper and most don't have the chance to study the difference in cultures. The Somalis who speak English and know the culture can educate the people about the knowledge that they have

learnt. Lack of knowledge is the problem that this community has right now. The community also needs education with health and problems facing the community.' (Somali male)

Discussion

Psychosocial factors and mental health

The findings support the hypothesis that social factors are significant predictors for general and mental health status. Inadequate housing, severe poverty, isolation and a lack of cohesive community social support were reported by all the participants to be detrimental to their mental well-being. All interviewees reported having emotional difficulties, mainly associated with the post-migratory resettlement process. While the role of traumatic experience should not be overlooked when determining the psychological illness patterns of these Somali refugees, the socio-economic adversity, lack of occupational opportunities, poor community support and poor housing appear to be just as significant, if not more of an influence on general, social and psychological well-being. Participants listed housing, employment and positive asylum applications as priorities for improving their life.

The findings revealed a much more complex picture of the causes, symptoms and perpetuating factors influencing the mental health of Somali refugees and asylum seekers in Camden, London. This deeper understanding goes beyond narrow diagnostic labels and requires a more relevant approach to prevention and treatment. There is an increasing conviction that the major detriments of health are based on cultural, social and economic interventions rather than medical ones (Dunn, 2000), and this is also reflected in the findings of this research. This view of health is primarily based on Engel's Biopsychosocial (BPS) Model of Health and Illness (Engel, 1980; see Figure 1). The model accounted for biological, psychological, and sociological interconnected spectrums, each as systems of the body and recognising that psychosocial factors greatly impact on the progression of, and recuperation from, ill health (Engel, 1980). The biopsychosocial model is an approach to medicine which stresses the importance of a holistic concept, a more complete, 'whole-patient-as-a-person'-type approach. It considers factors outside the biological process of illness when trying to understand health and disease. In this approach, an individual's social context and psychological well-being are key factors in their illness and recovery, along with their thoughts, beliefs and emotions.

In contrast, Dunn (2000, p.343) suggests that 'one's immediate social and economic environment and the way that this environment interacts with one's psychological resources and coping skills, shapes health much more strongly than the medical model would suggest'. This alternative model acknowledges the social, political and culturally constructed definitions and arrangements/experiences that determine an individual's expectations, knowledge and circumstances, and aims to move away from imperialistic ethnocentric preoccupations of diagnostic labels and psychiatric models of trauma. This requires that the social and political inequalities of power between different groups and within systems are explored when planning appropriate services and delivering care. In a clinical case study of a Bosnian refugee in London, Summerfield (2003, p.268) points to the limits of psychiatric and therapeutic treatments in treating a trauma victim 'who had not lost his mind but his world'. He argues that 'recovery is not primarily a mental process, subject to technical intervention by experts: it is embodied in the practical struggle to

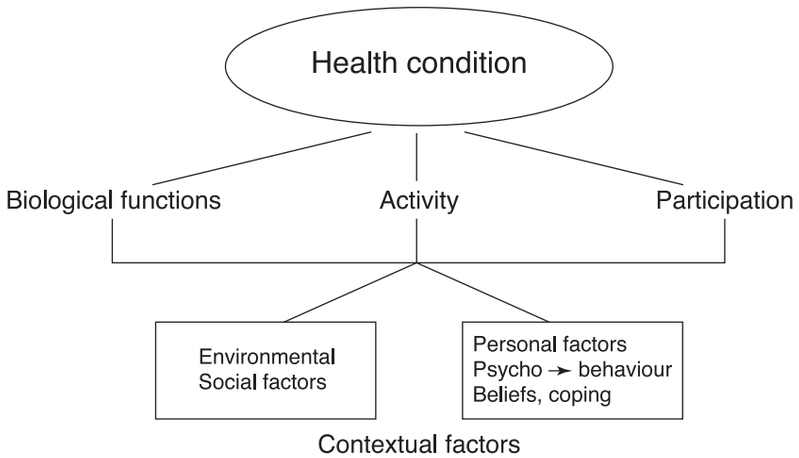

Figure 1 Biopsychosocial (BPS) Model of Health and Illness (Engel, 1980)

re-establish a life made viable by a sense of coherence' (Summerfield, 2003, p.268). It, therefore, follows that health is a holistic concept embracing an individual's social, physical and mental well-being, and influenced by social, economic, political and environmental experiences. In this way the solving of mental health 'problems' becomes an issue beyond that of the individual, rather encompassing the challenge of working with the organisation of key aspects of social life, to include housing, employment, legal status and community access. My research findings reflect this complexity with many social, cultural, economic and political factors being cited as contributory factors to mental distress.

Housing

A significant proportion ($n = 7$) of those interviewed presented being homeless or living in temporary accommodation as an issue. Housing is a concrete manifestation of socio-economic status, which has an important part to play in the development of explanations of the social production of health inequalities. Consequently, poor housing and homelessness will have an effect on psychological well-being. The home provides more than shelter, and the meaning of home, as for example a haven of security, is an accepted psychological and social construct (Brown and Harris, 1978). This is perhaps even more significant for refugees, in that something additional is being expressed in the meaning of home and safety, due to the personal and institutional migration process.

There has been a considerable amount of research connected with the psychological outcomes of poor housing on health (Brown and Harris, 1978; Heinrich, 1998; Blackman *et al*, 2001). Poor health in turn is likely to be exacerbated by homelessness (Trevena, 2001). Homelessness, including temporary accommodation, can increase the risk of suffering from ill health, with other contributory and linked factors including stress, alcohol and/or drug problems, respiratory disease such as tuberculosis, poor infant health such as low birth weight, infant mortality and adverse effects on child development (Marsh *et al*, 1999). Those living in temporary accommodation also experience significantly more mental and physical health problems than the general population, and those living in higher-quality housing (Vostanis *et al*, 1996). A particular factor impacting on the mental health of those who participated in this study was the lack of security associated with temporary accommodation, and the great uncertainty surrounding their permanent housing prospects. This experience of uncertainty meant that for many months, and in one case over three years, respondents lived with a fear that they might be made street homeless. Furthermore, a study of conditions in temporary accommodation concluded that it is often very poor with little privacy or security, shared kitchens and/or bathrooms and overcrowding (Palmer *et al*, 2001).

The causes of housing problems

Consecutive government policies over the last 30 years have impacted on the homelessness and destitution of respondents. Over the last two decades, the issue of asylum in the UK has become increasingly controversial and emotive, as successive governments have focused on reducing the number of asylum applications in the UK and on increasing the number of asylum seekers who are removed because their applications are unsuccessful (Heath *et al*, 2005). Some policies are designed to remove perceived incentives for asylum seekers such as the termination of support once a claim has been refused, and the restriction of support while a claim is decided. One of the consequences of such legislation is that it limits support and increases levels of destitution amongst asylum seekers whose claims have not been successful. One of the respondents in the study was destitute and without support, while others were being accommodated by friends and relatives, thus increasing the number of people in the community who are living in inappropriate, overcrowded and unsanitary conditions.

One of the biggest causes of homelessness amongst refugees highlighted by the homeless charity and campaign group Shelter London was the loss of National Asylum Support Services (NASS) accommodation (Shelter, 2003). It is evident that adverse housing and living conditions provided a considerable stressor for those who participated in this study, and appeared to exacerbate mental health problems which might or might not have been present already. Participants related worsening health conditions to homelessness, destitution and the poor standards in their accommodation. The fact that they tended to be generally living in worse conditions, with great uncertainty, and dealing with other issues related to the institutional migration process, was of grave concern to them. A consequence of inadequate temporary housing and homelessness is also directly linked to an inability to fully participate in the economy and society in general, and therefore also impacts negatively on education, employment and health outcomes (Blackman *et al*, 2001; Bradshaw *et al*, 2004).

Economic activity

There are no readily available figures regarding economic activity among the Somali population in Camden. However, none of the participants or any of the Centre's clients were in employment, despite the fact that some might possess high levels of education obtained in their country of origin. Everyone was in receipt of income support, incapacity benefit credits

or NASS support. Evidence suggests that Somalis suffer high levels of unemployment and are disadvantaged in the labour marked due to, amongst other things, language barriers (Harris, 2004). Participants expressed frustration with attempting to find employment, and felt they were not able to accurately represent their capabilities, thus impacting on and highlighting their deprivation and structural disadvantage. The inability to find employment, and in some cases reach their previous occupational and social status, impacted on the long-term mental well-being of those interviewed, and resulted in many experiencing feelings of hopelessness and despair.

Legal and institutional factors

The great uncertainty surrounding participants' immigration status prior to being granted refugee status resulted in a constant fear that they might be deported and returned to their country of origin. The challenge of dealing with the asylum and immigration system can encourage feelings of helplessness and despair, due to a lack of control over the situation. It is believed that humans' basic drive is to control their environment (Stipek, 1988). If an individual has a lack of control over an aspect of their environment in one situation, this will impair learning in similar situations (Ramirez *et al*, 1992). This lack of control can impact on self-esteem, perspective, and self-confidence, and consequently individuals can be locked in an internal pattern called 'learned helplessness'. Learned helplessness is understood as a motivational issue whereby failure or lack of control over a situation or situations makes the individual believe that they are incapable of doing anything to improve their situation, and consequently can have a detrimental effect on the individual's well-being (Peterson *et al*, 1993). Nearly all of those interviewed reported experiencing great distress and demoralisation, with one reporting suicide risks in the community, over immigration status or subsequent appeals. This distress and anxiety was frequently accompanied by emotional and behavioural reactions coupled with what can be determined as poor coping skills, which can be manifested in different ways.

Culture and perception

The findings suggest that perceptions of mental illness impact on access to and utilisation of services, which will potentially lead to continued marginalisation and social exclusion. The health of and issues of accessibility for Somalis are underscored by culturally specific understandings of mental health, stigmatisation of mental health issues and the treatment of illnesses. One of the most significant challenges facing those interviewed was the problem of perception. All participants drew attention to the difference in perceptions of mental illness in Somalia. Suffering from madness was not recognised as a medical issue but as a moral or spiritual one, and when people exhibited bizarre behaviour or thought patterns, they were liable to be stigmatised by their families and communities. The perception of mental illness within the Somali culture, in addition to narrow western interpretations, could result in a barrier to accessing community and mental health services (Palmer, 2007). The western mental health model of counselling was viewed as an alien concept, even when it was available in a relevant language. This situation was compounded by the fact that many of the psychiatric treatments available in the UK were rare or unknown, and viewed with mistrust.

Inextricably linked to the issue of perception is the problem of stigma. Participants overwhelmingly indicated that stigma had prevented them from engaging with health professionals. Stigma is a complex process of labelling that has many causes, is maintained by various structures and can occur at individual, community and service delivery levels (Weiner *et al*, 1988). 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. Unless cultural interpretations of distress are taken into consideration, individuals will not access services. In addition, misdiagnosis may occur and everyday mental distress can be mistaken for mental pathology.

Perhaps one of the most significant challenges impacting on inclusion and the health of participants was the issue of trust in the community and poor social connectedness. Many respondents reported having experienced distressing situations specifically with the pre-migration process, resulting in the breakdown of their ability to trust others in their community. 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 (Peterson, 2000). Expressions of lost social ideals and relations were mentioned several times in this research. Social support has not only diminished following migration, but a fundamental social and moral order has been eroded due to the pre-migration experience of war in Somalia. The belief that community support and trust are a natural part of social life is challenged by the migration process and by perceptions of mental ill health. Kinship ties among Somali groups may also impact on community participation. Griffiths (2002) comments on a diverse clan-based Somali community structure in exile, which replicates such groupings and tends to reinforce exclusive identities. The confrontation within Somali society impacts on community solidarity among Somali forced migrants, and therefore limits participation at a meso-level in urban regeneration, limits social enterprise and social inclusion, and discourages open and equal access.

Community participation and social capital

Issues of mistrust, stigma and perception of mental health which impact on community engagement and participation are clearly evident from the findings in this research and have implications for *social capital*. Social capital is associated with community cohesion and the existence of co-operative and accessible community networks/organisations that are considered trustworthy by community members (Kawachi *et al*, 1997). Many researchers have used Putnam's definition as their starting point, defining social capital as the 'features of social life – networks, norms and trust – that enable participants to act together more effectively to pursue shared objectives' (Putnam, 1995, p.70). Social capital, however, is a problematic concept, a recurring theme being the concept of trust 'which is based on shared norms and mutuality' (Gilchrist, 2004, p.4). Participants in this research talked extensively about the problem of trust between community members. Putnam and others argue that dwindling levels of social capital are not only responsible for poorer well-being, but also impact negatively on sustainable development, community and family integration and political development (Coleman 1988; Putman, 1993a,b, 1995). Social isolation is a recognised environmental factor in mental ill health, both causal and consequential, as a technical and measurable concept (Social Exclusion Unit, 2004). There is growing evidence of correlations between various dimensions of social capital and aspects of mental disorders and well-being, and this is starting to influence policy development with sustaining healthy communities now being a focus of the government's strategy to prevent mental ill health (Cullen and Whiteford, 2001). The effects of social capital on health are complex and contested, but the most common aspects are associated with the perception of trust in others and participation in voluntary organisations. Campbell and Jovchelovitch (2000) established that community participation, social support and trust are associated with reducing psychological distress. Household and community-level social capital interact with each other's development to erode or contribute to social development and well-being (Campbell and Jovchelovitch, 2000). Whereas small, tightly knit community groups may function well and assist their own members with practical and emotional support, they may also be exclusionary and even hostile towards perceived outsiders. The majority of the participants in this study reported that the issues of trust and stigma separated/marginalised them from accessing the support network of the community. They consequently had an outsider's status, and this impacted on their access to information, goods, support and services. As a result, they were caught between perceptions and inequality of two societies; they could not identify with the western mental health system, which was viewed with distrust, but they were also marginalised from their community. Membership of the Somali community networks appeared to be based on criteria of ethnicity and mental wellness and, as a result, the resources available to those suffering from mental ill health differed from those for individuals who were not perceived to be suffering in this way. External perceptions of mental health appeared to influence the nature of social ties within the community network, thereby impacting on relations between agents, social units and institutions. Such a network may isolate individuals, undermine community solidarity and consequently have a detrimental impact on integration and mental well-being. In addition, by not engaging with their members, the Somali community will not be able to develop the capacity to participate in wider networks and health forums at both meso and macro levels, in order to campaign for better health services (see Figure 2).

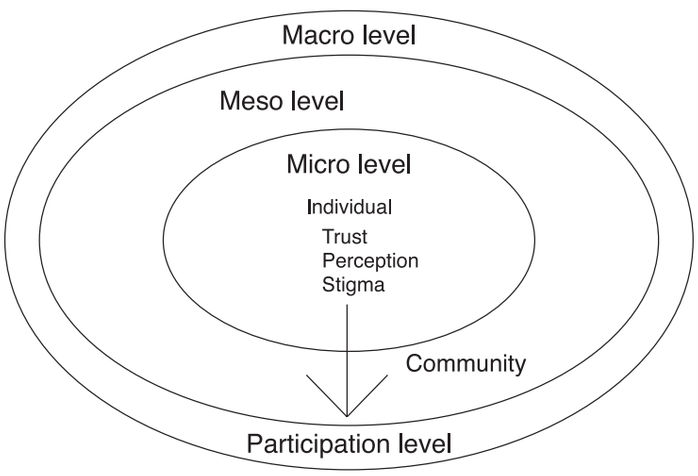

Figure 2 Community group participation and social capital

Conclusion and recommendations

This research involved a small number of respondents; the sample of nine people cannot reflect the whole refugee community. However, findings allow for some consideration of how the findings may impact upon the wider refugee population.

Psychosocial factors play a significant role in determining the mental ill health of Somali refugees living in the London Borough of Camden. The issues and impact of deprivation, combined with the complex interaction of social and psychosocial factors, are crucial when developing mental health service provision for refugee and asylum communities. It is apparent that economic deprivation, isolation, a lack of familiarity about services, poor housing conditions and the asylum process can exacerbate existing, as well as creating new, psychological stresses. For those who participated in the study, poor housing and homelessness were a significant factor of distress in the resettled environment. Similarly, persistent anxiety over the possibility of deportation and having to deal with the complex immigration legislation has also resulted in an increased level of mental distress and demoralisation, which inevitably impacts on mental well-being and emotional and behavioural responses.

This research explored how cultural perceptions of mental health can prevent individuals from accessing services and engaging with Somali refugee community groups. Participants felt that access to their community was limited due to mental health perception and stigma. They were not able to receive adequate services and support from their communities, and in turn they were not able to contribute to the debate on culturally appropriate service provision at a meso and macro level, which hinders integration and the development of social capital.

This research indicates that all mental health trusts services need to go beyond the clinical model and acknowledge the range of problems and issues experienced by those living in exile. By taking a wide perspective of mental health needs and redefining recovery to incorporate quality of life, providers and professionals can plan interventions, taking into account the multitude of social, political and administration factors, which can act as contributing factors to the long-term mental health of this group. As a result, health providers need to offer a holistic response to the needs of Somali forced migrants, providing advice and advocacy, social and emotional support, and access to appropriate housing, education and training.

To reduce stigma surrounding mental illness, strategies need to be multifaceted and have a co-ordinated approach to ensure that they reach community members, individuals and institutions. There needs to be a multi-level community education and training programme, where members of the Somali community such as refugee doctors and health workers act as positive role models. The programmes would demonstrate the possibility of positive outcomes, counter the negative beliefs within the community which stigmatise those suffering from mental ill health and encourage early action for those at risk.

The future for Somali refugee community groups

Participants reported that those experiencing psychological disturbance did not readily engage with the Somali community for fear of moral opprobrium. This problem of disengagement needs to be prioritised and addressed by Somali refugee community organisations (RCOs). This is made even more relevant by recent changes in government policy which require service providers, most notably the NHS, to engage with communities in order to improve services, making them culturally competent (Department of Health, 2005). If the Somali RCOs are not representative of those with mental health issues they will miss a vital opportunity to reflect the needs of their vulnerable and marginalised members. The organisations' inability to engage with people in need of mental health services will therefore perpetuate the negative spiral into increasing mental ill health. In order for there to be successful participation by Somali RCOs, effective training in mental health awareness must be provided for community leaders and members. Such training would need to focus on mental health issues in order to enable community leaders and workers to recognise the symptoms of mental ill health and, importantly work with members of their community in a supportive environment to combat any negative attitudes and stigma associated with mental illness.

Although social capital through engagement will not be enough to address all the difficulties facing the Somali community, it could be argued that it can have benefits for individuals. Social networks are believed to promote better health education, better access to health services and informal caring. Those interviewed had few assets in terms of economic capital, and limited participation, and this evidently impacted upon their well-being. The positive potential of Somali community groups is very evident in terms of their influencing and supporting their members through strategic and developmental awareness and activity, and therefore also placing themselves in a strong position to act on issues of inclusion, health provision and the social and economic detriments that impact on the well-being of their members.

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CONFLICTS OF INTEREST

None.

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