



A tool for services working with the Somali community on the issues of Mental Health

Mental Health Awareness
with the Somali Community



Tool kit developed from a Mental Health Education Project with Somali participants in Northern Melbourne, Victoria.

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May 2009

ACKNOWLEDGEMENTS:

ADEC would like to thank the following contributors to this project, Multiple and Complex Needs Initiative (MACNI), Victorian Transcultural Psychiatry Unit (VTPU), Dr. Kay Dufty and Dr. Marion Bailes from the Division of Northern GPs, Helen Walters from the Austin Hospital – Secure Extended Care Unit, Northern Melbourne Headspace, Donna Eade from Frontyard- Young People’s Health Service, Sheikh Issa and Sheikh Abdiwahab Ibrahim, Abdinur Weli from Spectrum, Yusuf Omar, Founder of the Australian Somali Youth Association (ASYA), MP Craig Langdon, our Somali bi-lingual workers Ahmed Tohow and Jamila Mohamud and all of the Somali participants from our project.

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INTRODUCTION:

The aim of this report is to help educate services not only on the Somali community, but also on how to work with this community on the issue of mental health in a more culturally appropriate way.

This report outlines the success of our project, the obstacles we were confronted with and how we overcame them. It will cover the lessons learnt from our first hand experience and also the ground work we accomplished with the Somali community as a result of this project.

Throughout this report, you will find some activities and checklists that we would encourage you to use to understand what *life* is like for Somali Australians and also to evaluate your own and your workplace's cultural awareness, competence, boundaries and limitations. I hope you enjoy reading this report as much as we enjoyed writing it.



'La La Land' Simulated activity:

Before addressing the background and experience of our Somali communities, it is important for you to first grasp an understanding of the emotions and circumstances they have been subjected to as a result of their country's situation. For this, we have decided to take you on a brief simulated experience, on a journey as close as practicable to the experiences of Somali refugees without having to physically go through the experience yourself.

Read through the following slowly, taking in every word, every thought and every feeling. For a moment, imagine you are a victim of civil war, scared, confused, lost, isolated, helpless and hopeless. Allow yourself to wander through your imagination and confront the feelings that you may experience if this were to happen to you right now.

Ok, let's begin...



La La Land :

Although it may be hard to envision, imagine Australia without all of its great features such as democracy, peace, harmony between people and freedom for everyone. Imagine it consisted of war-like conditions where nobody was safe. Some of your loved ones are disappearing and some have even been killed. At the moment there is nothing anybody can do to stop it. You feel fearful all of the time, you're scared to sleep and the situation is getting worse.

Based on these feelings you decide to escape until everything settles again. Someone offers to take you and some others to a country called "La La Land". Your friends and most of your family members don't trust the idea and stay back in Australia. You don't know much about La La Land but you know that it is safer there. So you leave without your family to go to La La Land...

Shortly after you arrive, you realize that the people in La La Land dress differently, eat different types of food, are very busy all of the time and they speak another language called *La*. You have never heard *La* before.

How do you feel at the moment?

The people seem strange but peaceful. A lot of them try to talk to you but of course you don't understand *La* language. You try to read their faces, gestures and behaviours, but you are still very confused.

How do you respond to this?

Would you be afraid of misunderstandings & misinterpreting?

In the 4 weeks that you have been in La La Land you have only heard your own language spoken once and that was when you had gone to the hospital after a fall. Fortunately someone was there that could speak English so they helped you to communicate with the doctor. You still had a lot of questions after this but as much as you wished to take this interpreter with you, he disappeared after 20 minutes.

How does this feel?

On your journey to La La Land, you had met one other person that speaks English too but they are the only person you know of. You don't like her too much but rather than seeing no one at all you chat to her sometimes. She gives you some tips and advice, however, you are just not sure if you can trust her. Back in Australia, she wouldn't have seemed like a trustworthy person at all ... **but what other choice do you have?**

You and the others are eventually shown a little house and all of you are given some money. Your basic needs such as food & shelter are now met.

So you'll be ok now? Or do you feel like you need something else?

As time passes, you try very hard to understand their language. However, it seems very confusing for you and you would rather not talk at all. Your family & friends are still in Australia in constant turmoil. You only have minimal contact with them, and every time you do, it's extremely difficult for you to hear about how dangerous and terrifying Australia is for them. Although you would like to bring them over to safety with you, this process is lengthy and takes time. You don't even know how to do it. You're in a country where you can't even communicate with the locals.

Given this, could they even help you? Can you trust them?



(For the full version and experience of this and other simulated journeys, please contact ADEC to arrange a training time for you and your workplace)



**QUESTIONS TO ASK YOURSELF ABOUT YOUR
La La Land EXPERIENCE:**





QUESTIONS:

- **What thoughts are going through your mind after working through this imagination?**

- **Think back to when you first arrived in La La Land and you observed the way the people talked. What feelings did you experience? Maybe you were excited, scared, confused or overwhelmed?**

- **Did you question whether you had made the right decision by going to La La Land? Did you want to go back home?**

- **Was the idea of safety more important than the new challenges and experiences you were going to go through on La La Land?**

- **What were your initial thoughts about living within the community?
(Remember their way of talking, their dress code and behaviours.)
Did you feel as though social inclusion was possible?**
 - **If so, how long do you think it would take you to feel comfortable in your new surroundings?**
 - **If not, how do you think you would manage to live in a community that you would never be a part of?**

- **Because their customs and dress code are different to yours, does it make them wrong? If not, then would you embrace these customs? If they're not wrong, then there shouldn't be a problem in practicing them, should there?**

- **Would you trust these people? If not, what would they have needed to do to earn your trust?**
- **Would you try to learn their language and if so how? Or would you want them to talk English with you?**
- **When they provided you with food and shelter, did you feel you were missing anything? Did you need more? Your basic needs were met, does that mean that you were going to be OK?**
- **Would you have been brave enough to have gone out and explored the area, culture and life around you?**

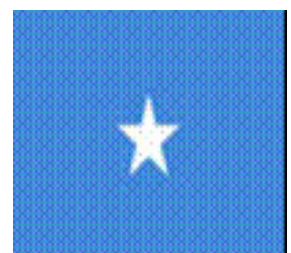
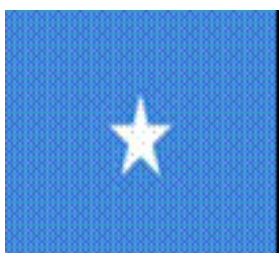
Would you have given up by now?



Although this simulation may have seemed *ridiculous* and 'out there', we believe it was important for us to be extreme and push the boundaries of commonsense in order to put you in a place that was uncomprehended and bizarre, much like the experience of war and migration would be for someone if they were to experience it for the first time.



BACKGROUND TO THE SOMALI COMMUNITY:





Belief system:

Somali people are well known for their strong community bond and display quite generous attributes towards their fellow community members. They have a strong value and belief system which they trust in completely, and believe that one's health and destiny is GOD given and therefore it can not ever be changed. Because of this belief, Somalis spend little time worrying about the future, instead they spend their time praying and staying close to their GOD (ALLAH). When one of their community members becomes unwell, whether physically or mentally, it is believed that either GOD has caused this to the person because they have done something wrong or do not pray enough, or that an evil curse has been placed on them for past wrong doings.



Leaving war:

Since civil war broke out in Somalia, Somalis have been fleeing to countries all over the world, including Australia. During this migration period, the majority of Somalis were forced to live and survive in refugee camps, where they would witness and be subjected to crime, usually on a daily basis. Many were forced to fight for food and their safety was never guaranteed. During this time, they remained cut off from society and also their family and loved ones. They had no way of knowing if anyone was in trouble, hurt, or even deceased. After a lengthy stay in these camps, they eventually gained refugee status and were offered placement in other countries. Even years after leaving these camps, the traumatic experience remains fresh in all of the victims' minds.



Dilemma of acceptance and trust:

While still experiencing the negative repercussions of war, such as Post Traumatic Stress Disorder, severe anxiety and depression, Somali's were also dealing with the unusual and unfamiliar experience of living in and adapting to their new host country. After living a life where they initially felt safe, comfortable and like they *belonged*, in Australia Somalis found it difficult to understand Western culture, our government policies, our laws and also their rights in our country. Still to this day, some Somali people are finding it challenging to understand western values and norms, in contrast, some Australians and western services are experiencing the same difficulties embracing Somali values and norms when working with or engaging with them.



Facts and statistics:

According to the Australian Bureau of Statistics (2006), in 1996, 3,000 Somali's had migrated to Australia. This number increased to 11,000 by the year 2006. Of these Somali's, 62.2% of them live in Victoria, and it was found that most of them reside in Melbourne's northern suburbs. Since Somalis began migrating to Australia, settlement programs were put in place. However, due to the severity and lasting impacts of their pre-migration trauma, mistrust for others has made the migration process challenging. For many, the migration experience has produced confusion with their identity, triggered mental health issues, disrupted their education, hindered their employment status, produced economic dependency, lowered their social status, altered their family roles and impacted on their ability to cope with stressors. Their concerns for their family members

still overseas are constant, combined with the stress of needing to learn a new language and adapt to a new culture with different values. Their struggle to understand our government practices, such as paying money to our youth, have been a challenge for this community. Iredale and D'arcy (1995) also argue that the shock produced from uprooting a person from their home has the ability to cause a very intense reaction and as a result produce a "permanent" obsession with the past and a total rejection of their host country. This is especially common among the elderly.



SOMALI MENTAL HEALTH AWARENESS AND
EDUCATION PROJECT
BACKGROUND:

ADEC received funding to conduct **Somali Community Mental Health Education**

ADEC recruited a **male and a female bi-lingual educator** from Somali backgrounds

ADEC conducted a **focus group** with mature Somali men

ADEC conducted a **focus group** with mature Somali women

ADEC conducted a **focus group** with Somali male youth

ADEC conducted a **focus group** with Somali female youth

The need for education about mental health arose

The need for developing an information brochure arose

ADEC conducted an **information session** for the mature males about mental health and its treatment in Australia and Somalia

ADEC conducted an **information session** for the mature females about mental health and its treatment in Australia and Somalia

ADEC held 3 **workshops** with the Somali youth to develop the brochure

ADEC held a **forum** (mixed genders) with presentations from local services, GPs, hospital and Sheiks

ADEC held a **launch** of the brochure (mixed genders) with presentations from the services referred to on the leaflet as well as a Sheik

ADEC disseminated the brochures, developed a final report about the project in the form of a "Tool Kit" and held presentations at services, radio interviews, newsletter articles etc. about the project

After receiving funding to provide the Northern Somali community with mental health education, ADEC decided to hold focus groups with the community to first assess their needs. Two Somali bi-lingual workers, one male and one female, were employed to assist with this process and recruit participants.

Very early on in the project, it became apparent that having a worker from both genders was a crucial aspect in order to recruit and retain participants throughout the project. This was due to belief systems Somalis hold regarding cross gender encounters.

Also from liaising with our bi-lingual workers, it was recommended that we divide the focus groups into four separate groups. First separating the males from the females for cultural reasons and then separating the mature adults from the youth, because it was assumed that the youth should have a better understanding of mental health from their school education.

In addition to this, given the youth would predominantly be of second generation, it was thought that they may view mental health from a mixture of both Somali and Western ideas, rather than purely from the Somali belief system, as we assumed the mature adults predominantly would. Therefore different views and discussions were expected to arise from these two age groups.



FINDINGS:

(Please note that these findings are from ADEC's personal experience with the Somali community in Northern Melbourne, Victoria, and may differ from other Somali communities and research findings).

From our four focus groups, it was apparent that mental illness is still hugely stigmatised within the Somali community and that diverse definitions, symptoms, causes and treatment forms for mental illness exist between the 'Somali' and 'Western' perspectives. These differences include, but are not limited to, the Somali belief system that a person is only perceived to have a mental illness if they exhibit psychotic symptoms and their behaviour is extreme, for example, running naked through the streets. Mental illness is usually thought to be caused by evil spirits (Jin-devil) or be a form of punishment from God, and that treatment for this is predominantly treated internally with close family members through reading the Koran and praying with sheikhs and religious elders.

Identified views about mental illness within the Somali community:

The following views were identified in the focus groups:

- People with a mental illness are 'crazy'
- People with an intellectual disability have a mental illness
- People with a mental illness are dangerous and unpredictable
- People with a mental illness should not be interacted with
- The mature groups believed that a person with a mental illness would *never* recover

From our group discussions, it was identified that there was no clear distinction between mental illness and an intellectual disability for the community; they were both thought to be the same thing. Furthermore, given that depression symptoms are very common within the Somali community as a result of both their past traumas and the migration process, depression symptomatology was therefore not viewed as an illness but rather a fact of life.

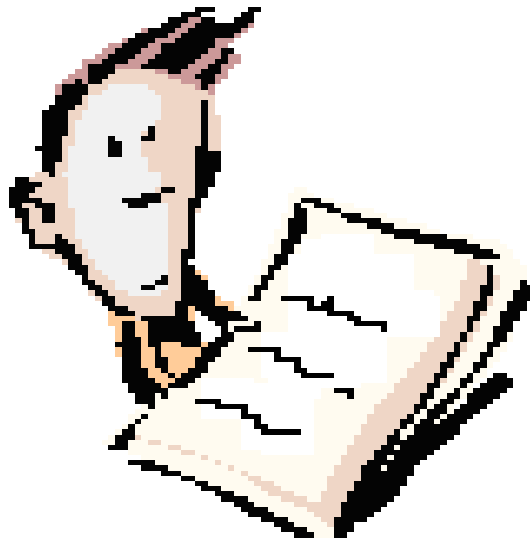
The most common fears identified by all of the focus groups regarding a person with a mental illness were, that the person was violent, dangerous and unpredictable, and also the stigma experienced as a result of a mental illness diagnosis. All of the groups stated that they would be either hesitant or unwilling to assist or support a person with a mental illness, and it was evident that the participants lacked vital information regarding medication and its effects, believing that it will cause a person to become debilitated. The participants also lacked any knowledge of available mental health resources and services, they had no understanding of what the services did, and were therefore hesitant if not unwilling to access these services.

When addressing the impact on a person with a mental illness and the community's response, it was acknowledged by all of the groups that the person would most likely experience a loss of honour and privileges, stigma from the community, bullying and strained family roles which would then lead to relationship difficulties, isolation and limited support for the person with the mental illness. From the focus groups, there were four common requests identified regarding the type of information the Somali community required about the issue of Mental Illness. They were, psycho-education on what mental illness is, having mental illness normalised to them, knowledge on how to identify early signs of mental illness and what mental health services and resources are available to the community.

From this information, we decided to provide our mature participants with two mental health education sessions. The first session would cover mental health, what it is, both the 'Australian' and 'Somali' perspective, and signs and symptoms, whilst the second session would address the local mental health services, what they provide and how to access them.

For our youth participants, it was agreed that a brochure would be the best way to reach our target group, consisting of information identifying the myths about mental illness and what services were available to their age group.

(For the full findings from our focus groups please contact ADEC's Transcultural Mental Health Department. For a copy of our mental health youth brochure, please refer to Appendix A)



OUTCOMES:

The feedback from our session evaluations was very positive. The participants were all unanimous regarding the helpfulness of the education sessions to both their personal situation and the community's situation as a whole.

Some key points raised during the evaluation process were the relief that mental illness had been *normalised* to them. The Somali community had held the belief that mental illness symptoms existed solely in their community and was not common or experienced in other cultures. Therefore it was comforting for them to learn that mental illness exists *everywhere*.

Another important element was around the issue of confidentiality. Prior to our education sessions, the Somali community was unfamiliar with the practice of confidentiality, which in turn hindered their willingness to seek professional help. Since our sessions, it was commented that the participants feel more educated and empowered about their rights and therefore more confident in approaching 'western' services should they require help.

The importance of seeking help and early detection was reinforced, in addition to the possible benefits of treating a mental illness both spiritually and professionally at the same time, rather than using only one method.

The participants found it of great importance to receive education about medications, as it lowered their anxieties around side effects and possible addiction. They also found the information we included on the community's accepted drug *Khat* very useful in identifying its possible contribution to a mental illness and ultimately assisting the community members to make an informed decision regarding their personal substance use.

It was commented that the sessions supported the community to acknowledge the symptoms of mental illness and therefore educate themselves about it. All of the participants stated that they felt more confident on how to identify mental illness signs and symptoms as well as where they could go for support if things become difficult for them or others around them.



CHALLENGES:

Throughout our project, we were confronted with many challenges, some more difficult than others. The obvious challenge was that of gender issues. Being of Muslim religion, the Somali community are one of many communities in which particular practices around gender are very important. Not abiding by these strong gender values will more than likely hinder a service's possibility of working productively, if at all, with this particular community.

From discussions with both our Somali bi-lingual workers and the participants of our focus groups, we were informed that for the Somali community, it was important that not only males refrained from touching the female participants, but if the genders were to be combined into one group, the seating arrangements would have to be altered and input from the female participants would also be minimal, if at all. This was because in the Somali culture there is a clear gender hierarchy that exists. Females are not to sit next to males, instead they sit behind them at the back of the room, nor are they expected to voice their opinion in their presence, as it is assumed that the males would speak on their behalf. Eating in front of males was also raised as a concern for the females.

Other challenges we faced throughout this project were around finding an appropriate time and venue for the participants to attend our sessions. We had to ensure that the venue was local and known to the community, to avoid people not attending due to transport reasons or for being unfamiliar with the venue. Not only was this convenient for the community, but we believe the issue of 'trust' played a role in the need for a familiar venue as well, as the limited trust the community still has for 'western' culture and services may have prevented them from venturing into unfamiliar grounds.

Finding an appropriate time to accommodate everyone's schedule was one of the most challenging tasks. We found that it was difficult for a number of the female participants to attend sessions during the day due to work commitments, however more than half of the female participants were unable to attend the session's afterhours because they were looking after their children whilst their husbands worked.

The males were divided in their availability as well. The older males found it more convenient to attend day sessions because they no longer worked, the younger of the mature males worked during the day and therefore a day session would not suit. The male participants whom were taxi drivers worked long shifts, usually 12 hours, which was even harder to find a suitable time for them.

Although it would be impossible to accommodate everyone, it is still extremely important to ensure all of the community members have the opportunity to attend the sessions if they wish. Mental Illness education is vital information that the community needs in order to both help them cope mentally and emotionally, and encourage and support their integration into society, which in turn, may increase their use of available services.

Promotion of the forums was not an easy task either. The Somali community is a predominantly 'oral' community, so the most successful promotion of any event would be through word of mouth. However, with ADEC's minimal Somali contacts prior to the project, a lot of the promotion had to be left up to our bi-lingual workers.

Although we hung fliers in venues associated with the Somali community and a community radio station was utilised for promoting the project, it was still extremely important to make use of our bi-lingual worker's connections and rapport within the community. This was because the community would view the project as coming from an unfamiliar 'western' service and therefore trust would come into play yet again. Hence, we needed our bi-lingual workers to not only 'spread the word', but also encourage participation and provide reassurance to the community members that the project would be helpful to them.

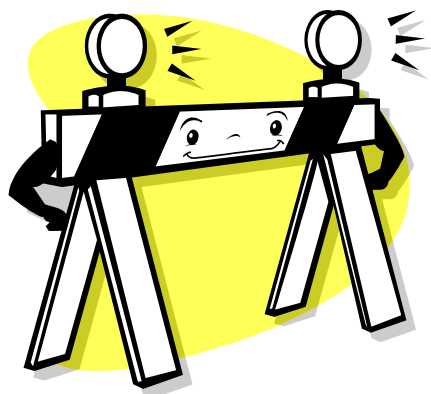
Punctuality was a challenge throughout the project as well, as the Somali community possess a different perception of time. Because of this, it is quite common for the Somali community to arrive later than expected. This occurred for every session we held, even after checking with the participants prior to the sessions on what time suited them best. Cultural rituals, such as pray time, can also influence the community's attendance and therefore would need to be considered.

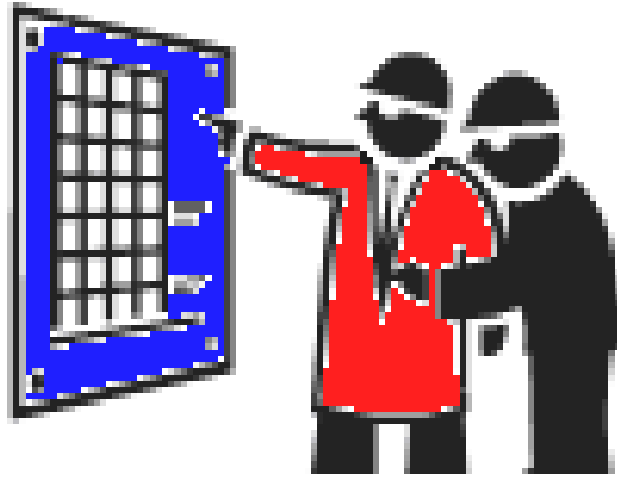
Another challenge we faced when working with this community was the expectance of payment. Although our education sessions would provide the community members with all of the information they had asked for from our service, we found that there is a cultural expectancy from the Somali community to be rewarded through payment for their time and efforts. Due to this expectation it was difficult to recruit attendees, furthermore, we experienced a high drop off rate as the sessions progressed. Because of this factor, lengthy projects would need to be very well thought through and provide a clear incentive to the community.

The final major challenge we experienced with our project and working with the Somali community, was the need for our bi-lingual workers to often use their personal phones when contacting the participants to inform them of times, venues and other important information. Although it could be argued that the use of personal phones was crossing a service's professional boundaries, we had been informed from our bi-lingual workers that the participants would not answer their phones if they did not recognise the number.

In addition to this, it was also sometimes necessary for our bi-lingual workers to contact some of our participants after business hours and on weekends due to their time restraints. After reassurance from our bi-lingual workers that they did not have any concerns with using their personal phones, and given the fact that the participants that they would be contacting were 'friends' and 'acquaintances' of our workers, we decided to allow this practice for the purpose of this project.

Although this practice would not be recommended if avoidable, we felt that it was an important point to mention, in order to make you aware of both the community's expectations and needs regarding information distribution.





CONCLUSION:

As you can see, the Somali community are witnesses to and survivors of intolerable suffering and torture, separation from and torture of their loved ones, long periods in refugee camps, and recipients of the negative affects of migration. As a result of their experiences, they are more susceptible to mental health and integration difficulties. Although this is so, from our experience, it is not common for this community to complain about their situation or experience, however they are in need of awareness and education around what they are experiencing.

From our project, ADEC has been successful in beginning the process of educating the Somali community on mental health, alleviating some of their common concerns regarding mental illness, familiarizing them to 'western' forms of treatment and also in connecting them in with some of the local mental health services.

Although progress has been made, there is still a lot of work to be done, especially around stigma, medication and 'western' services and treatments. We found that the participants both *wanted* and *needed* the information provided, however more effort needs to go into building a trusting relationship with the Somali community to make it easier when delivering future educational projects and to increase the available options.



RECOMMENDATIONS FOR FUTURE PROJECTS:

RECOMMENDATIONS:

- From the focus groups, it was evident that the Somali community responds quite well to information and advice provided by their local Sheiks and Imams. Considering the fact that at this point in time the community is still reluctant to trust Western approaches and services, it would be recommended that future mental health education be provided to the community's Sheiks and Imams. It is thought that by doing this, the religious leaders could then continue providing mental health awareness to their community long after a service's project has ended, as well as encourage their community to access the available health services. Educating sheikhs and Imams could also help to reach the community members whom are unable to attend education sessions due to time restraints. For example, taxi drivers.
- It is highly recommended that the genders be separated at all times to achieve the best information input from the participants and therefore quality project outcomes.
- As previously mentioned, only 1-2 sessions for a project should be a service's aim to try to avoid a high drop off rate. It is also important that the sessions are not too lengthy, due to the community's time restraints. Arranging sessions during particular times of the day, such as 'praying time' should also be considered and avoided.

- If possible, running a day and night session to accommodate for the community's timetables (women working during the day and men working at night) would also be beneficial to a project.

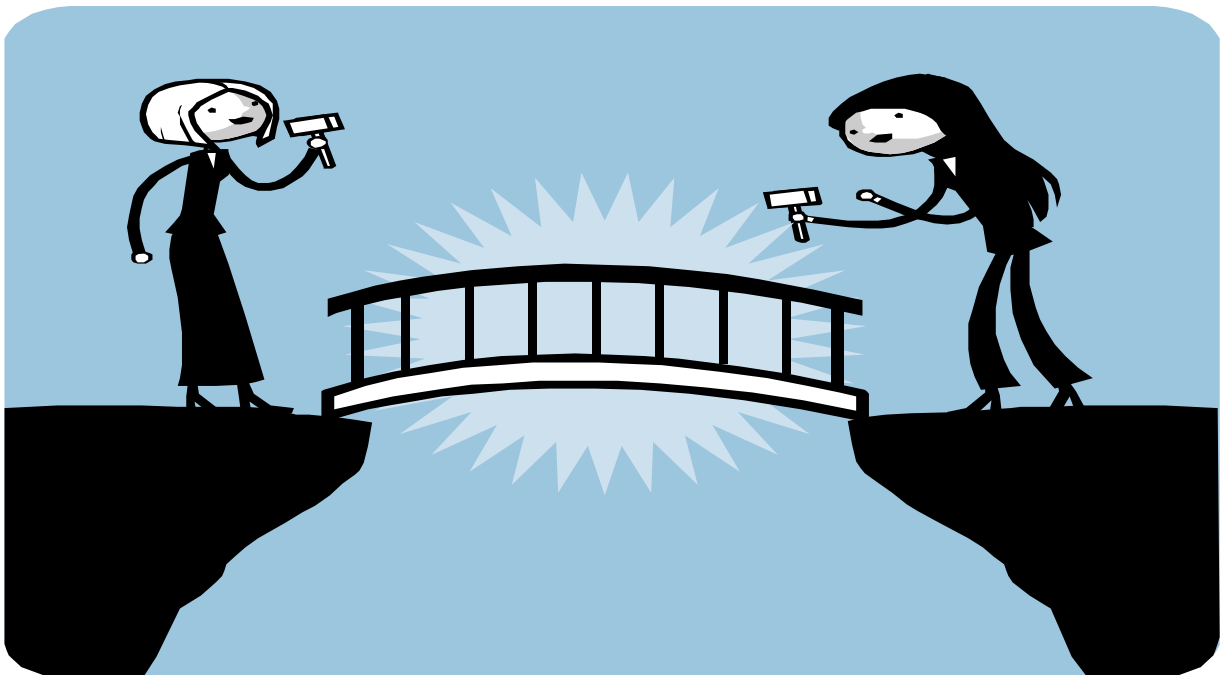
- Enquiring about regular group meetings the participants attend, such as English classes, is also beneficial to avoid booking sessions that will clash with their other commitments.

- Where possible, consider providing your sessions during a pre-existing program, for example, Koran classes. By doing this, your participant numbers should remain steady and the time would be suitable for everyone attending. The participants also won't have any extra commitments, which would be less of an inconvenience for them.

- Making the women's session 'child-friendly', to accommodate and entertain the children who are not of school age could increase their participation rate and the length of time the female participants could stay.

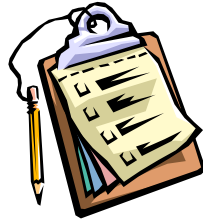
- A fear of the health system was also evident amongst all of our focus groups, therefore more education around this topic would be highly recommended.

- Although our project has begun the process of building relationships and trust between the Somali community and western services, consistent engagement is essential for the continued interaction. Bridging this gap through creative ways of communication, i.e. recreational, social or educational activities could also prove to be very beneficial.





TOOLS:



How culturally sensitive are you and your workplace?

	YOU		WORKPLACE	
	✓	⊘	✓	⊘
* Are you/your workplace open to cultural differences and different ways of doing things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Do you/your workplace respect diverse practices and requests without judgement?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Do you/your workplace assume you know what a client wants or needs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Do you/your workplace react adversely to a client's accent?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Do you/your workplace use simple language and avoid technical terminology?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
* Do you/your workplace know how to book an interpreter?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

YOU

WORKPLACE



*** Do you/your workplace feel comfortable using an interpreter?**

*** Do you/your workplace suggest using an interpreter when interacting with a client from a CALD background whose proficiency in English is inadequate?**

*** Do you/your workplace listen to the client and notice nonverbal communication that indicates emotion associated with the topic?**

(Questionnaire adapted from Multicultural Mental Health Australia's *Cultural Awareness Tool*, 2002).



CHECKLIST:

**IMPORTANT POINTS TO CONSIDER WHEN WORKING WITH THE
SOMALI COMMUNITY:**

From ADEC's experience with this project we found that;



It was not only important, but *vital* for a service to understand, acknowledge and respect the Somali community's experiences and unique cultural understanding of mental health in order to build rapport, trust and enable an effective working relationship with the community. It was apparent that when trust has not been gained from the community first with *any* service, the communities' willingness to participate, co-operate, learn or provide any helpful information would disintegrate quite rapidly.



Consideration of gender issues is very significant. Culturally appropriate customs such as separating the genders or positioning females away from the males without the expectation to speak whilst in their company needs to be accommodated for.



Access to bi-lingual workers from both genders would be highly recommended.



Where appropriate, use the bi-lingual workers as an added resource in educating your service on the community you are working with. Liaising with them could prevent a disappointment or challenge later on in your project.



To avoid missing any valuable information, first, familiarise yourself with the common terms used by the community to describe the particular problem. From our project, we found that the Somali community described mental health symptoms as either having a 'headache'; or 'back pain'. This is believed to be due to three factors. The first being, the community's English skills are often quite limited, so finding the right words to describe their symptoms is difficult. The second factor is the community's lack of knowledge around mental illness signs and symptoms; therefore they do not understand their situation and in turn struggle to describe it accurately to their doctors. The third factor is in relation to stigma. As stigma around mental illness is still a strong and influencing aspect within the Somali community, it is common for its community members to hide their actual mental health status to ultimately avoid alienation and repercussions from their community.



When posing questions to the community, it is important to always be patient and listen to their entire answer, even if it appears as though they are going off the topic. We found that valuable information, sometimes even more valuable than the actual answer to the initial question can be uncovered through this method, because it allows you to delve even deeper into the community's thinking and culture than initially intended.



Allow extra time at the beginning of your session for late arrivals, at least 30mins. Punctuality is a common challenge with the Somali community.



It is highly recommended that a venue that is both convenient and familiar to the Somali community be used for any sessions. Familiarity for this community appeared to be an important aspect for our project, which was thought to be due to the limited trust the community has for 'western' culture and services.





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APPENDIX (A)

Mental Health Youth Brochure:

(Developed in partnership with the Northern Melbourne Somali youth)