

Somali Conceptions and Expectations Concerning Mental Health: Some guidelines for mental health professionals

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The Somali population in New Zealand is a rapidly growing one that should be of interest to mental health professionals due to their experience of resettlement stressors and the refugee histories of many Somali. Many factors contribute to barriers and difficulties between mental health professionals and Somali clientele. We present here some of the cultural and religious issues influencing Somali conceptions and expectations about mental health services in an attempt to reduce barriers and difficulties. While Somali views are diverse, many view "mental illness" as only encompassing the most severe and possibly untreatable cases. Few Somali see war-related trauma as a direct cause of their problems but instead cite preoccupation with reunifying their families or other resettlement stressors as direct causes. We outline some traditional treatments, especially the common use of Koran readings for dealing with both physical and mental health problems. Somatization of problems leads to a heavy reliance on General Practitioners. Complications with specialist referrals and inadequate cultural skills and knowledge of professionals aggravate adequate treatment with this population. Problems with translation and miscommunication are very common. We recommend that health professionals spend more time finding out about clients' family and community relationships, carefully explaining diagnoses and treatments, and listening to, incorporating, and facilitating Somali views on mental health issues and traditional treatments.

50 per cent of refugees present mental health problems ranging from chronic mental disorders to trauma, distress and great deal of suffering." (p. 1). In the *Refugee Voices* project (New Zealand Immigration Service, 2003), one-third of the interviewees reported having emotional problems related to experiences prior to moving to New Zealand and related to moving to and settling in New Zealand. The *Refugee Voices* project also reported that 60% of those had not seen anyone relating to their emotional problems or concerns and that one-third wanted some sort of help relating to the stress they were experiencing. Despite evidence that refugees in general have above-average mental health service needs, there is other evidence that many Somali refugees in New Zealand do not access the services available for many reasons (Yates, Diiriye, Guerin, & Guerin, 2003). These include language barriers, inappropriate use or lack of interpreters, unfamiliarity with the provision of such services, bureaucratic barriers, and transportation issues.

Somalia comprises a majority nomadic culture with low western education levels and literacy, particularly among older men and women. With the civil war there has been no government for a number of decades and a non-consumer-oriented, non-western economy, meaning that Somali life and culture is very different to that in New Zealand. The majority are Muslims, and have many contacts with the Middle East rather than the rest

Although there have been many cross-cultural approaches to understanding mental health (Aponte, Rivers & Wohl, 1995; Cheung & Snowden, 1990; Cuéllar & Paniagua, 2000; Ekblad, Abazari & Eriksson, 1999; Ferguson & Barnes, 1997; Ho, Au, Bedford & Cooper, 2003; Ho, 1987; Minas, 1991; Monteiro, 1995; Narduzzi, 1994), they have often focussed on westernized groups such as Asian Americans or Hispanics. Literature relating to mental health issues of refugees resettled in western countries is more limited. In particular, little is known about: 1) how the western conceptions of mental health

impact on resettlement of refugees from non-western countries and; 2) what the conceptions of mental health are for these groups. The purpose of this paper is to provide mental health professionals with some background to issues in mental health relevant to Somali refugees who have been resettled in New Zealand.

There are now about 4000 Somali in New Zealand, most of whom have arrived as quota refugees or as part of family reunification. Many of those will have mental health needs (Cheung & Snowden, 1990; Elmi, 1999). Brundtland (2000) points out that "it is established that an average of more than

of Africa. They primarily speak Somali but the language was only put into a written form in 1972 (using English letters) so many of the older people cannot read or write their language, since they always had an oral tradition. Many also speak Arabic and Swahili. The social organization is very kin-based and the communities often close. While this was based on a clan system in Somalia, many have rejected this form of organization because of the trouble it caused the country (for a more detailed review of Somali social organization, see Abdullahi, 2001; Ahmed, 1995; Farah, 2000; Guerin & Guerin, 2002; Kahin, 1997; Lewis, 1994).

Somali are a particularly interesting group to study in relation to the western approaches to mental health service provision because of the many issues that make them different to typical 'westerners'. Briefly, these include differences in religion, skin colour, education and literacy, and culture in general. Nearly all Somali are Muslims, practicing the religion of Islam, requiring women to dress in ways that sets them apart from other New Zealanders. This, combined with their black skin, makes the women particularly visible in New Zealand communities.

What do Somali people think about concepts of 'mental health' and how might this thinking influence standard mental health service delivery? While Somali views are highly diverse, they still usually differ in many ways from a person brought up in western society, and it is therefore useful for practical workers in the mental health fields to get a feel for Somali perspectives even when still working within western models. In this paper, we present comparisons between western and Somali conceptions of mental health, their respective treatments, and some issues and solutions confronting both Somali and practitioners in mental health care.

Methods

The information provided in this paper comes from discussions and interviews with a total of 30 people, participant observation over a number of years by both Somali and non-Somali researchers, research projects in the

community in Hamilton and elsewhere, and from overseas literature. More specifically, findings relating to mental health from a previous study on general health involving 54 people (Guerin, Abdi, & Guerin, 2003) are mentioned as well as findings from intensive interviews relating to mental health service experience with six Somali women (Yates et al., 2003). Other research of ours (Guerin, Diiriye, & Corrigan, 2003; Guerin, Guerin, Diiriye, & Abdi, in press) has also informed the writing of this paper. Through all of our research and community experience, we work together with multi- or bilingual interpreters when required. Finally, the paper was co-authored with a Somali researcher and drafts were reviewed and commented on by two other Somali.

When we refer to "Somali" in this paper we are generally referring to middle-aged or older Somali who would have spent the majority of their lives in Somalia or Kenya, who speak very little English, and who would have had only some contact with western ways prior to coming to live in a western country. Younger, more westernised Somali may have very different views to those expressed in this paper (Guerin, Guerin, Abdi, & Diiriye, 2003), but it is the older group who, for many reasons, are at a greater need of mental health services. For example, older Somali are more likely to have had no education and may be illiterate even in their own language (therefore translating health information into Somali may not be helpful). Older Somali will also likely have not experienced bureaucracies and consumer-focussed economies which will influence their ability to negotiate day-to-day expectations in New Zealand (e.g., keeping receipts when making cash payments to various companies as proof of payment). Dissemination of the richness of the information we have acquired both formally and informally, and relaying its importance to mental health professionals are the purpose of this paper.

Mental Illness: Somali and Western Definitions

Through our work, we have found two parallels between Somali ideas of mental health and western classification. Specifically, what we understand as

'schizophrenia' and what would be judged as mild or moderate depression or anxiety in the western system (DSM-IV; APA, 1994), both relate to two basic categories in Somali understanding.

The first Somali category we describe is that of serious 'madness' or belief in possession of an individual by a ghost or spirit, which in western terms relates very generally to manic depression (bipolar disorder) or the more severe forms of schizophrenia. However, this belief in possession is largely connected to a religious understanding of the Koran and aspects of the will of God rather than to individual mental health, per se. When we ask Somali to tell us what they think 'mental illness' means (e.g., Yates, 2003), they have said that it is when someone is mad or insane, or when they go around throwing stones, yelling, hitting, eating from dumpsters, and walking naked. When we have asked how these people are treated in Somalia, we are told that these individuals are considered a danger to themselves and others so are placed in seclusion facilities in hospitals, or if they live in the country far from a hospital, they are chained up to protect themselves and others. An important implication of these ideas is that if Somali hear themselves being described as having mental illness, this is the sort of picture they might envisage and they might therefore resist treatment. In a similar vein, a Somali may indeed resort to these sorts of behaviours in order to access treatment, as they may believe that it is only by behaving in this way that they will get the attention or treatment that they need. Mental health workers therefore need to be careful about how they describe mental illness to clients and also when investigating the function of a client's behaviours.

The second broad Somali category of mental illness is that of not being well in general (a lack of well-being). This category is more variable and more related to social issues than are similar western ideas, but it is closely related to mild or moderate depression or anxiety. When we have asked Somali about the key diagnostic terms such as depression, anxiety and post-traumatic stress disorder, it is clear that these terms

are unknown, and indeed many have told us that these problems do not exist in the Somali population (Yates et al., 2003). This parallels the results found by Elmi (1999) that depression and concepts of stress are not recognized in traditional Somali health care. However, these forms of mental ill-health are often described by the Somali word "walli" which is commonly translated by Somali as "crazy". This is not a good translation, however, and it is probably best translated or thought of as saying "They are not feeling themselves," "They are not doing things normally," "They are acting funny," or "They are distracted". The term is used in diverse situations and can be applied to a child with ADHD, someone with bad headaches, someone with insomnia, or to someone who keeps forgetting where things are. The use of the term also arises in casual conversations, especially as a joke when someone forgets something or does something silly, and so is not restricted to cases of mental ill-health. While the word describes a person, and seems to make a dispositional attribution of the cause, the causes of "walli" are talked about by Somali as much more social and situational than similar western ideas, again suggesting that 'crazy' is not a good translation.

Other Relevant Mental Health Concerns

Another important Somali conception of mental health is that many believe there is not a problem until it begins to 'interfere' with everyday life. Although many mental health professionals would agree with this, what is considered 'interfering' might be very different than what most mental health professionals consider 'interfering.' Thus, frequent crying, insomnia, and chronic headaches, which in western ideas would relate to depression or somatization disorder, in Somali households is unfortunately often accepted as a part of life or not serious enough to warrant treatment or any particular concern. This is not due to insensitivity, but, rather, the often large family has so many other more immediate concerns. This means that a delay between onset and accessing help for problems is likely (Yates et al., 2003)

as is the potential for escalating problems.

Of other common clinical issues, drug and alcohol problems within traditional Somalia were relatively unheard of for the majority of the Somali population, with most following the Islamic faith and the Koran which forbid the use of alcohol and other drugs. However, there are now cases reported of Somali males with drug and alcohol problems and even some women who smoke cigarettes or drink alcohol. Khat (Qat) is a tobacco-like drug common in Africa and Arabia, and while users of Khat do not consider it to be a drug, there is a growing awareness of similar problems associated with its use. Khat is a stimulant (amphetamine-like) that comes from the leaf or buds from the tree *Catha edulis* (*Celastrus edulis*). It is chewed like tobacco, usually by males (Qat, 2003). Khat use is not uncommon among Somali in New Zealand and there have been legal problems mostly associated with the acquisition of the plant from private properties. Accessing the plant in New Zealand is not as easy as it was in Africa, although there are well-known sites of the trees in the North Island for which some will travel long hours to access. Practitioners need to consider the possibility of Khat use particularly among male Somali clients and the possibilities of withdrawal effects due to its being difficult to access. These issues should alert clinicians that although the vast majority of Somali practice Islam, there is the possibility of alcohol or other drug abuse (including Khat) among this community.

While "Africa" has been the focus of concerns and high rates of HIV/AIDS, until recently the prevalence in Somalia has been uncommon or non-existent due to strong religious beliefs (Gray, 2004). However, rape in camps and unsanitary medical practices might contribute to a rising HIV/AIDS rate among Somali, but the lack of effective government in Somalia combined with the dispersion of Somali worldwide contributes to a lack of statistics. Our knowledge of the New Zealand Somali population indicates that, while there are cases of HIV/AIDS infection, it is kept very secret, even from the closest family

members, because of the belief that HIV/AIDS infection is only from sexual promiscuity. Most Muslims are exclusive in their relationships although divorce and re-marriage is perhaps more common than for westerners. Many Somali we have talked to also express disbelief about gay and lesbian relationships in the west, and especially gay marriages. While it is possible that homosexual relationships in Somalia are kept secret from most of the population for religious reasons (MASK, 2003), many we have talked with find it difficult to believe they exist and some even describe people in these relationships as mentally ill. This general belief may also contribute to secrecy and fear of disclosure among the Somali population for both HIV/AIDS infection and non-traditional relationships.

Most of the Somali in New Zealand have experienced first-hand the traumas of war and conflict, including basic food and water shortages, poor health, death, rape, torture and imprisonment, but very few claim these as causes of their problems (Stuhlmiller & Dunning, 2000; Yates et al., 2003). Even so, professionals around the world are quick to cite war-related trauma and Post-Traumatic Stress Disorder (PTSD) as the causes of both serious and low-end mental health problems among Somali. Our experience is that the people themselves see their problems as principally involving family who are still overseas or missing, from resettlement problems and the unexpected difficulties of fitting into a new country, and from generic problems such as being unable to speak English well-enough to get things done, chronic unemployment, and economic problems (Bhui et al., 2003; Guerin, 2001; Paul, 1999). Many Somali report, for example, that the principal causes of headaches, insomnia and rumination—key elements of PTSD—are separation from family and the difficulties associated with negotiating the immigration bureaucracy to bring those loved-ones to New Zealand.

From a western perspective, treatment of PTSD often relies on cognitive-behaviour therapy or psychotherapy that focuses on the trauma experienced, or pharmaceutical

therapies (Foa, Keane, & Friedman, 2000; Peterson, Prout, & Schwarz, 1991; Scott & Palmer, 2000). Some, but not all, of the Somali women we spoke with during in-depth interviews reported that repeating past trauma details to each new professional was traumatic in itself, and that solving family separation would be more helpful (Yates et al., 2003). For many Somali, traumatic experiences are readily accepted (but not always) as "God's will" whereas traumatic experiences in a western perspective are assumed to require therapeutic treatment (but see Bracken, 2002; Bracken & Petty, 1998). The spirituality and reliance on God (i.e., Allah) may be a major contribution to much of the resilience of Somali (Brune et al., 2002; McMichael, 2002) but requires more research.

Treating Mental Illness for Somali

In this section, we will discuss the traditional Somali treatments for mental health concerns and the western challenges in considering these treatments. Our research has highlighted Koran readings, community counselling, and complementary and alternative therapeutic approaches in the Somali community as ways to deal with mental health concerns.

Many cases of mental illness, and even physical illness, are dealt with in the Islamic community with Koran readings and praying (Basher, 2001). An Imam or key person of the community reads verses of the Koran to the ill person, usually with family and other community support present. The verses are carefully chosen depending upon the conditions, and readings can be held in a short session (lasting maybe an hour), can be held in short sessions over a number of days, or readings can sometimes extend over three days and nights or more. The social and familial support inherent in these sessions also has a major function and probably contributes to their success. Formerly, in serious cases, the person might also be whipped or caned with sticks or cloth, sometimes hard, but this practice seems to have disappeared except for an account from Auckland of a very light whipping or perfunctory stroking of someone during a treatment. With

research demonstrating the benefits of belief systems in coping with trauma practitioners should be facilitating and supporting clients in their requests for such treatments (Brune et al., 2002).

The medicalised nature of mental health problems in the western system has led to perhaps more prescriptions of anti-depressants and other psychotropic medication among Somali than is necessary. It has to be remembered that the effectiveness of these drug approaches are likely to be severely compromised in this community due to language barriers, adherence problems, and cultural barriers to drug use (Yates et al., 2003). Because the anxiety and depression problems are considered to be due to excessive worrying about missing family, treatment might better involve referrals to advocacy and other assistance either in addition to, or rather than, medication or talking therapies.

For the less serious types of mental health problems, a sort of family and community counselling is employed, which may or may not involve religious leaders. This is not surprising given that most problems are seen as family troubles or relating to family relationships. Almost exclusively, men counsel men and women counsel women, although both can also go to the Imam of the mosque. 'Counsellors' are usually family members or elders in the community. This 'counselling' most closely resembles arbitration, where the key people involved talk through the situation and the elders can give advice or make a decision as to who is at fault and how they may be required to make amends. Even though elders are meant to be unbiased in their assessment of the situation there are reports of gender biased outcomes in some male-female family conflicts. Even so, we have seen many family and community problems dealt with successfully this way, and traditionally they are a good solution to the "low-end" mental health problems.

One example of community support is a particular case of marital conflict resolution. A man had hit his wife (not habitually) and she told him to leave and divorce her (women generally cannot divorce but can demand that the man divorces her). The man wanted to reconcile, so following an initial

agreement by the wife, the husband was required to attend many meetings with the men and women of the close family and community. Eventually, over a period of a week or so, a gathering was held on consecutive nights at each house of the main kin involved, in which most of the relatives were present and food was served. At each of the gatherings, the husband apologized publicly to relatives and others from the community. It is interesting that in this particular case the wife was living overseas and was not present at any of these gatherings and at the conclusion of the gatherings he left to go overseas himself, but to another country, not the one where his wife and children were residing.

Finally, Somali practice the use of complementary or alternative therapy in the form of massage therapy with anise seed oil. Accessing anise seed oil in New Zealand is expensive so other lotions and oils are sometimes substituted. This massage therapy is used particularly for pain, headaches and backaches, which are widespread problems in our work with Somali. Somali we have talked to are more open to physiotherapy, massage, and body therapies as treatments rather than to prescription drugs, and there is a wide variety of related traditional methods for dealing with physical medical conditions (Yusef, Adan, Egal, Omer, Ibrahim, & Elmi, 1984). These could certainly be used more in the future, either alone or in conjunction with western forms of mental health treatment.

A contemporary challenge to these community and traditional solutions, however, is that family and community dynamics have changed for refugee Somali who are resettled in western countries such as New Zealand. While there is still a strong commitment to community ways of life, and a strong reliance on extended families, the families have been changed through deaths and missing persons, changes in relationships, and being placed in unusual and untenable situations. Demands on the community and on families are stressful in general and even more so for community members with better English and western bureaucratic skills. For example, a woman suffering

“post-natal depression” might have formerly relied on female family members to assist with childcare and day-to-day household duties, and these family members would have lived close by or even together in the same house. Childcare responsibilities were also very different in refugee camps or in Africa compared to New Zealand. In New Zealand, the family available may now live too far away to help easily, requiring a car and driver’s license, and the relationship with family may be strained due to years of separation from civil conflict and the time required to get through bureaucracies to get reunited. Hence, the social support in the community is not what it once was and should not be assumed by health professionals.

Problems and Solutions in Mental Health Services

Our research has found that while some interviewees who had been through the mental health services did well and were very pleased with the western treatments and services provided, others experienced a range of barriers and difficulties (Yates et al., 2003). We have identified some key areas presenting problems in the adequate treatment of mental health concerns in the Somali community. These include: a heavy reliance on General Practitioners (GPs); problems with the referral system; translation and interpreting difficulties; cultural mis-match in diagnosis, aetiology and treatments; and bureaucratic barriers.

We have noted elsewhere that there is a strong reliance by most Somali on General Practitioners (GPs) as the sole contact person for all health matters (Guerin, Abdi, & Guerin, 2003). Many are not in contact with mental health services and rely solely on their GP, possibly because GPs are in the community rather than centralized in a hospital or central business district, because GPs are known to them and their families, and because GPs are usually trusted and respected (Guerin, Abdi, & Guerin, 2003; Yates et al., 2003). The down-side to this is that many Somali are apprehensive about informing GPs if they disagree with their diagnoses or treatments or if there are side-effects of drugs the doctor was not

expecting—they do not wish to contradict a GP. Other authority figures in hospitals and elsewhere are also viewed with some fear and suspicion since Somali may regard them as having power to revoke residency, withhold appropriate treatment, or hinder reunification procedures. Some interviewees were worried that if they said something offensive to a doctor, even that their medications were not working, then they would be forced to leave New Zealand or that information gained from the doctor would be used against them in some way (Yates et al., 2003). To make this worse, Somali have a history of limited knowledge about individual rights and are unlikely to understand their rights in the health services. Also, many do not know the differences between social workers, nurses, psychiatrists and psychologists, complicating their understanding and expectations of services.

Referrals to mental health services are often problematic. Many times the clients do not understand what the specialist referral is about or why they need to go. As mentioned earlier, if they are told they need to see someone special for “mental health” problems they are likely to get the wrong idea, but not telling them anything is problematic as well. They may also prefer to go for Koran readings rather than specialists because they feel that this is more helpful. Finally, like other non-western groups (Trudgen, 2000), Somali may not follow western time schedules and keep appointments, especially if they have to wait for long periods when they do show up on time. Many Somali do not read at all, especially English, and referral appointments are usually made via the postal system. A letter from the hospital can be seen as junk mail and thrown out, not because they do not care, but because they cannot read. Tied in with translation problems, more is needed in the way of explaining to clients the reasons for their specialist referrals, what their diagnoses mean, their rights, and the full details of any prescription medication. More time is also needed in obtaining background to the issues, since these most frequently involve much more complex family and community histories than typical

western examples. Complex and stressed family dynamics are a key issue in the well-being of Somali but need time and contact to work through.

A constant problem for all concerned is that of translating English in such a highly specialized, abstract and sensitive domain. Inexperienced translators and family members are likely to misinterpret, even with the best intentions, so a governmental-level overhaul might be required at this point. New variations could be tried such as linking in with 24-hour telephone translation services based in Australia, (as some governments departments are doing), putting money into training more local Somali to act as permanent specialist translators, or encouraging more Somali to become qualified as nursing and public and mental health professionals themselves. There are additional problems: some English-speaking Somali resent it being assumed they will need an interpreter; some professionals do not bother to get interpreters (especially if it is a situation in which the Government does not pay); inappropriate interpreters may be called to an appointment, such as a male for a female appointment; and sometimes inexperienced interpreters can easily get the interpretations wrong given the sensitive and highly specialized talk involved. Often family members are brought to appointments as interpreters, typically children, and each appointment might see a new and younger member of the family there to interpret. While frustrating for everyone, the situation is unlikely to change for some years, and this is a key area for improvement.

Cultural mismatch in diagnosis, aetiology and treatment is another major area of concern. For example, prescribing drugs for mental health concerns is problematic in that clients do not necessarily understand the reason for the prescription and, for example, are often simply told things like, “This pill will make you happy”. The use of and adherence to drugs such as anti-depressants is a very complicated matter, even for educated clients who speak English well, and is therefore compromised with Somali clients. A good interpreter is absolutely essential in these cases to explain the delayed

nature of the effect of the medication and the possible side-effects (McManus, Mant, Mitchell, Britt, & Dudley, 2003; Mihalopoulos, Pirkis, Naccarella, & Dunt, 1999; Yates et al., 2003). In general we have found that mental health specialists are better at adequately explaining medication details compared to GPs, perhaps because GPs have greater time-pressure and often do not have experienced interpreters present to help, and often the GPs do not refer on to specialist mental health services. All of this results in Somali obtaining information about medications from friends, families, interpreters and other people in the community when the medication does not work or it has adverse side-effects. These issues are particularly problematic in the use of antidepressants for which adherence is a problem for most people and its effectiveness depends upon strict compliance and frequent communication with the prescriber. Employing more refugee mental health co-ordinators throughout New Zealand would alleviate some of the problems encountered with both drug prescriptions and accessing interpreters.

Two other concerns expressed by clients about western treatments are that mental health professionals focus too much on past experiences (trauma), rather than problems in the current situation. Also, to some clients, it seems that the mental health professionals are learning from the clients and find them interesting and exotic rather than focussing on trying to help. We cannot assume these to be true in general, but it is worth making sure that clients have no cause for these beliefs. The first of these, in particular, is important. For example, one woman, who did have a very traumatic past of being shot and witnessing the murder of family members, was repeatedly asked by mental health professionals to talk about it, partly because of high turnover in the profession. She asked the interpreter, in Somali, "Why do they keep asking me about this? I always leave here crying and very upset. All I want is for my daughter to come here from Africa." Many Somali, however, cannot see a benefit in sitting and talking about problems with a stranger outside of their family and community. Also, the utility

of talking about past traumas is compromised because these stories may have been told over and over to authorities in order to gain refugee status and acceptance to New Zealand in the first place. From a Somali perspective, sitting and talking can also seem a frivolous luxury in the context of multiple other stressors that require immediate attention. Granted, for practitioners, balancing all of the issues when working with Somali clients is a challenging task and the building of trust is a known difficulty in work with refugees (Reichelt & Sveaass, 1994; Sveaass & Reichelt, 2001).

If professionals spent more time finding out about the complex and intricate family and community relationships, this would help diagnoses greatly. There are many examples we know of diagnostic labels being given without the professional really having any chance of understanding what is going on. One first-hand account was

of a label of depression being given (followed by a prescription for antidepressants) when the client merely asked about weight control methods. While weight concerns are a known problem among Somali women (Guerin, Diiriye, Corrigan & Guerin, 2003), the relation of that to depression is only a speculation. Even if the diagnosis was correct, the method of delivery was obviously unsatisfactory given the little knowledge in the community about western conceptions of mental health.

Finally, there is a more general problem with accessing and following instructions from western bureaucracies. Many Somali are not only unfamiliar with western bureaucratic processes but have a bad history of government authorities and their misuse of powers. This comes both from living in a dictatorship with strong intelligence gathering services, and from living in refugee camps where both authorities and the refugees monitored what

Table 1. Recommendations for treatment and policy in the mental health care of Somali refugees.

Issue	Treatment Implications	Policy Implications
Language	Ensure appropriate use of interpreters Allow extra time in appointments	Ensure specialist referrals are both written and oral (e.g., phone to remind of appointments)
Medications	Diligence and thoroughness when explaining why medication is being prescribed, possible side effects, how long to take, how often, etc.	Any psychopharmaceutical prescription should be made in conjunction with interpreters, mental health service workers, and community workers
Specialist services	Liaison with specialist services when possible	DHB's implementation of MHC recommendations of MH service delivery for refugees
Creative use of Interpreters and Community Brokers	Community members could act as liaisons and even assist in writing reports that provide a better background and context	Assist more community members of ethnic groups to be involved and to achieve appropriate qualifications for being mental health professionals
Community Knowledge and Involvement	Whole-family approach: find out about family structures and dynamics (e.g., are there key family members still overseas?). Inquire about use of community approaches, eg., Koran Readings and other community groups with each client. Familiarise with ethnic client's culture, history, etc. Visit if possible and talk with cultural brokers and community workers	Professional time allowed for community involvement

everyone was doing. In the struggle to acquire refugee status and gain acceptance to a western country, social rules go out the window, corruption abounds, and rumours hold a lot of power. Many older Somali are very sceptical of anything coming from people in bureaucracies.

Conclusions

Five main problem areas to meeting the mental health needs of Somali are apparent to us. Table 1 lists these with some solutions discussed. The first involves better handling of language and communication differences, including referrals to specialists. The second relates to more attention paid to medication prescriptions and the consequences. A third relates to the need for specialist services in which many of the issues addressed in this paper are accommodated. Fourth, a more creative use of interpreters in the adequate treatment of clients could be employed, and better use of community brokers as lay-community mental health workers or, better still, helping them to attain appropriate qualifications. And finally, increased involvement by mental health professionals in the communities they are working with is essential. Some of the suggestions are expanded below.

In New Zealand, specialist services for refugees are available in Auckland, Wellington, and Christchurch, but more are needed and the effectiveness of those services needs to be determined. Mental health professionals and the Somali community need to collaborate in order to resolve some of the current issues. For example, refugee mental health co-ordinators could assist in educating the community about western conceptions of mental health and its treatments, as well as informing professionals about traditional treatments such as Koran readings and finding ways to incorporate them into western treatments if possible. Our experience has also highlighted the necessity for liaison between all agencies and services involved with a client and their family. For example, mental health professionals should liaise closely with a client's GP, especially when a client is on a variety of medications or if their medication has changed. Liaison between services will

ensure that a client is getting appropriate care, can help to identify gaps in care, and that there is not overlap between what services are providing. For example, a client may ask their GP, their social worker, their mental health worker, each to write letters of support for government housing, thereby overstressing the already strained government housing service. This liaison could be orchestrated through a specialist mental health service.

Another suggestion is that interpreters and knowledgeable people in the Somali community become more involved in the reports that are written and passed between mental health professionals, even if they have no qualifications in mental health. They could act as consultants for the community and be part of a more creative use of mental health report-writing (cf. Alexander & Bloch, 2002). Such persons have only been involved in interpreting and transport typically, but the main points of reports could be translated into Somali or a key person asked to comment on what has been suggested. We know of many cases in which the Somali support person or interpreter involved correctly predicted that a treatment was not going to work. Some consultation with them and the client could prevent a lot of frustration for all concerned, although privacy issues would have to be addressed.

Whether or not the Somali views on the social causes and social treatment of mental illness are correct, another clear recommendation is for those in mental health and other health services to be much more involved in, or at least knowledgeable about, the communities (Burns & Firn, 2002; Manderson & Allotey, 2003). We recommend that professionals find ways of getting to know the community and the people, by visiting homes, attending social functions, and interacting with interpreters beyond the work business, especially if they cannot liaise with a community as suggested in the previous paragraph. Having other family and community members present during consultations would be quite useful in some cases, but the professional would need to be very clear about the situation first. If someone from the wrong family was brought in it would hamper the

whole process. Finally, there is a strong role for synthesizing western mental health treatments to more traditional religious treatments, physiotherapy and body-work, advocacy, and social network facilitation (McPherson, Harwood & McNaughton, 2003). Once again, with these functions synthesized, having a refugee mental health co-ordinator would support the professionals in carrying out, what are for them, unusual roles.

These suggestions are all supported by the World Health Organization Report for 2001, *Mental Health: New Understanding, New Hope*, which was devoted to the topic of mental health. The report refers to the special nature of refugee mental health and the need for policy relating to this. Specifically, in relation to refugees, the report states, "policies must deal with housing, employment, shelter, clothing and food, as well as the psychological and emotional effects of experiencing war, dislocation and loss of loved ones. Community intervention should be the basis for policy action" (p. 83). The report also identifies the importance of preventive measures in the treatment of mental health and that mental health policies and programmes should be developed with the communities involved.

In closing, the needs and issues for Somali clients as addressed in this paper present both general health and mental health care professionals with a number of challenges to 'standard' services. The successful resettlement of Somali in New Zealand depends upon either extending current services to meet these client needs or establishing and developing specialised services.

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