# BEST PRACTICES:
# *"SOMALI FAMILY MENTAL HEALTH SUPPORT PROGRAM"*

A partnership project between Midaynta Association of Somali Service Agencies, Family Outreach & Response Program and Somaliland Canadian Society of Metro Toronto.


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## Section # 1 Somali Family Mental Health Project

### Background

The Somali Family Mental Health Project was the result of a collaborative effort from many members of the Somali Community and a few mainstream mental health organizations. The release in September 1999 of A Study on the Mental Health Needs of the Somali Community in Toronto by Abdullahi S. Elmi was the impetus for bringing concerned people together to address the challenges outlined in the report.

In the Spring of 2000, Somali community leaders and mental health professionals met with mainstream professionals. Organizations that were represented included: Dejinta Beesha, Somaliland Women's Centre, Somaliland Canadian Society, Midaynta, Canadian Centre for Victims of Torture, Across Boundaries, Canadian Mental Health Association, Community Resources Consultants of Toronto, and the Family Outreach and Response Program.

For a year and a half, these organizations met to discuss strategies pertaining to Somalis having difficulty accessing mental health services, the overwhelming stigma of mental illness in the community and the need for culturally and linguistically relevant services. Focus groups were held with a broad range of Somali Community members to ensure as much input into the process as possible. As a result of the focus groups and ongoing discussions with the larger group, it was decided that funding was required to address the needs.

The group agreed that Midaynta, Somaliland Canadian Society and the Family Outreach and Response Program would develop a partnership for a funding proposal to the Ontario Trillium Foundation. This proposal was for a three year funding to hire two part-time family mental health support workers. The purpose of this proposal was to educate the Somali community about mental health and ensure that supports are provided to the whole family in a culturally and linguistically appropriate way. In January 2002, the Project was given approval by the Ontario Trillium Foundation. The original group then became the Steering Committee for the Somali Family Mental Health Program.

### Challenges

In the initial stages of the project, the key challenges were developing trusting relationships between Advisory Committee members as well as between partner organizations. It was also critical to the success of the project to have an Advisory Committee that represented all of the diversity within the Somali Community. While there may have been conflict due to cultural tensions between clans, these historical differences did not impede the progress of the Advisory Committee.

Another challenge was to clarify the role of non-Somali partner agencies and to ensure that their participation was valuable and respectful of the Somali culture. The most difficult challenge was to ensure funding sustainability which has not been successful. While the project has developed tools that will be useful for others on an ongoing basis such as the educational video and this manual, the Advisory Committee has not been able to secure ongoing funding for staff.

## Section #2 Community Outreach Strategy

### Workshops

Outreach to the Somali Canadian community in the Greater Toronto Area for this project took place in three phases. The first phase entailed staff going out into the larger community to disseminate information by word -of -mouth and through designed workshop sessions. These gatherings and meeting places include women's support groups, seniors groups and youth groups. The information dissemination also involved getting in touch with other Somali community agencies in the City of Toronto and tapping into their existing groups for other projects.

### Brochures

The second phase involved the preparation of the Somali Family Mental Health Support program brochure which details the information of the program and its services to those with mental health problems and their families. This brochure was written in both Somali and English languages so that it is more accessible for those with language barriers in the community. The brochures were distributed to mental health organizations and to places where Somalis congregate. This was followed by organizing the more formal workshop sessions prepared and facilitated by program staff in partnership with other agencies. These workshops were slow to recruit participants in the beginning stages of the project but over time it began to be well known and increased attendance by the Somali community.

### Mental Health Conference

The third phase involved the preparation of the 1st Somali Mental Health Conference in the Greater Toronto Area. For more of the details on this conference, please refer to section #4 of this booklet.

### Radio Show/Video/Audio Productions

Advisory Committee members for this project participated on local Somali radio shows speaking about mental health issues and the Somali Family Mental Health program. This community outreach strategy also included the production of a video and an audio tape translated into the Somali language. The contents of these two tapes include a more concise and detailed information on mental health problems and access to culturally appropriate services available in the Toronto area.

### Challenges

The main challenges with the Family Mental Health Support program were that there is overwhelming stigma about mental health problems within the Somali community which created a resistance to hearing any information regarding this subject. Initially, the project would advertise their activities around themes such as stress as opposed to mental illness. With increased information and resources being disseminated to the community, there now seems to be less resistance to and more acceptance of the fact that mental health problems exist. There were more people open to discussing their personal stories and that of their loved ones with mental health problems and the healthcare system.

## Section #3 Community Education and Awareness

### Workshops:

24- Workshops were designed to take place throughout the three-year-project.

### Topics

- Recovery Model
- Stress Management Techniques
- Different Forms of Mental Illnesses & Symptoms
- Stigma Reduction
- Medications and their Side Effects
- Family Nutrition
- Mental Health and the Law
- Anger Management
- Suicide Awareness
- Post-partum Depression
- Advocating for Family Members

### Presenters:

The presenters came from a variety of community organizations both Somali and mainstream:

- Midaynta Association of Somali Service Agencies
- Flemingdon Community Health Centre
- Midaynta Association of Somali Service Agencies
- Regent Park Community Health Centre
- Rexdale Community Health Centre
- Central Neighborhood House
- North York Women's Shelter & Horn of Africa
- Schizophrenia Society of Ontario
- City of Toronto Department of Public Health
- Somali Family & Child Skills Development Services

### Partner Agencies in the Greater Toronto Area:

Many or the workshops were done in partnership with other agencies. This helped to facilitate the outreach and attendance of the workshops as family members already has a relationship with the partner agency.

- Dixon Community Services
- Dejinta Beesha

- Rexdale Community Health Centre
- York Break Down The Barriers to Senior Project.
- Flemingdon Community Health Centre (East African Program)
- Central Neighborhood House
- Across Boundaries
- Regent Park Community Health Centre
- Canadian Centre for Victims of Torture
- North York Women's Shelter
- Horn of Africa
- Bader Da'awa Centre
- Schizophrenia Society of Ontario
- Somaliland Women's Organization
- Isolated Women's Program – Midaynta
- East View Community Centre
- Family Outreach and Response Program
- Family Mental Health Alliance
- Somali Family and Child Skills Development Services

## Challenges/Strategies:

◊ Keep the size of participants between 10-25 people so that participants are can maintain interesting discussions and exchange of ideas.

◊ Allows time to talk about their own experiences with stress and methods that they have used to overcome them.

◊ Give time for questions and answers.

◊ Use other names such as: "Family Health" and "How to Cope With Stress" because when mental health is used as a label for sessions it becomes difficult to bring people out.

◊ Know your audience so that as a counselor you are able to identify stressors and causes of mental illness in that particular group and include them in the discussions. For example, if you have a group of young mothers make sure that Post Partum Depression is emphasized and with youth you can have a discussion around Intergenerational Gaps. Isolation and loss role as a matriarch or patriarch within the family structure are key factors for seniors.

## Educating Mainstream Agencies on:

◊ Value of cultural competence within domain of mental health services.

◊ Cultural competence and its role in provision of health services to recent newcomer communities particularly refugees who have experienced the horrors of war.

◊ Sensitivity training for mental health service providers and increasing their awareness about the barriers that exist for refugees in Canada.

◊ The benefits of information sharing between ethno cultural communities and mainstream agencies when providing mental health services.

## Section #4 1st SOMALI MENTAL HEALTH CONFERENCE IN TORONTO

### 1st Somali Mental Health Conference

The first ever conference on mental health for the Somali Canadian community was held in Toronto Canada on April 3, 2004. This conference set the stage for comprehensive education and awareness building campaign by the Somali Family Mental Health Support Program. This was an opportunity for increasing the education and awareness of mental health issues for individuals, families and the larger Somali Canadian community.

### Presenters

This conference created an opportunity for beginning the dialogue on mental health problems within the Somali Canadian community. The presenters at this conference included Somali Canadian psychiatrists, family physicians, nurses, case managers, counselors, family support workers and spiritual leaders. The conference was well attended by the Somali community in Toronto and surrounding areas.

### Evaluations

| | Presentation/Category | Total | (1) | | (2) | | (3) | | (4) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | M.H. = Mental Health | Evalua-tions | Poor | % | Fair | % | Good | % | Excel-lent | % | Total |
| 1 | Background: M.H. Risk Factors | 51 | 1 | 2 | 1 | 2 | 8 | 16 | 41 | 80 | 100% |
| 2 | Family & Community Supports | 51 | 1 | 2 | 1 | 2 | 13 | 25 | 36 | 71 | 100% |
| 3 | Crisis Management & M.H. | 51 | 2 | 4 | 1 | 2 | 10 | 20 | 38 | 75 | 100% |
| 4 | Family Members Perspectives | 51 | 1 | 2 | 3 | 6 | 8 | 16 | 39 | 76 | 100% |
| 5 | Medical System and M.H. | 51 | 0 | 0 | 1 | 2 | 7 | 14 | 43 | 84 | 100% |
| 6 | Spirituality & M.H. | 51 | 0 | 0 | 3 | 6 | 6 | 12 | 42 | 82 | 100% |
| 7 | Overview of M.H. Resources | 51 | 0 | 0 | 4 | 8 | 9 | 18 | 38 | 75 | 100% |
| 8 | Question & Answer Period | 51 | 0 | 0 | 4 | 8 | 9 | 18 | 38 | 75 | 100% |
| 9 | Food and Catering | 51 | 0 | 0 | 2 | 4 | 7 | 14 | 42 | 82 | 100% |
| 10 | Organization of the Conference | 51 | 0 | 0 | 2 | 4 | 9 | 18 | 40 | 78 | 100% |
| 11 | Overall Quality of Conference | 51 | 0 | 0 | 0 | 0 | 9 | 18 | 42 | 82 | 100% |

### Some of the comments included:

- ◊ It is important to educate the community, particularly families with loved one with mental health issues.
- ◊ Very good, should be an annual event.
- ◊ I liked and learned a lot about mental health and how it affects our community.
- ◊ Useful handouts and information resources on mental health issues.
- ◊ I particularly enjoyed the confrontation between the psychiatrist's views vs. the spiritual and traditional healing views.

Challenges:

- One of the main challenges was to ensure that the conference was as accessible as possible. So the conference was held on a Saturday in a location that was close-by to one of the large Somali communities and the language spoken was Somali.
- Another challenge was to ensure that many viewpoints were acknowledged especially the traditional views as well as the more mainstream views of mental health.
- Another challenge is being respectful to Somali culture e.g. prayer time, male and female spaces.

Following are Somali terms (names) that indicate mental health issues. These terms/names were collected from the discussion period of the 1st Annual Somali Mental Health Conference on April 3, 2004 at Etobicoke Civic Centre.

Mental Health Support = Daryeelka Maanka (Somali)

1. Buufis
2. Dhimir
3. Waalli
4. Wareer
5. Wal-wal (wel-wel)
6. Walbahaar
7. Walaac
8. Qac
9. Laba-miirre
10. Khal-khal
11. khafiif
12. Isku-yaac
13. Isku-buuq
14. Isla-hadal
15. Ku-dhufasho
16. Ka-dhig
17. Dawakhaad
18. Maraan
19. Maryo-Dhigad

## Section #5 Somali Family Mental Health Counseling/Support:

### Important part of the program is the family support and it usually depends on the family needs. Examples:

- ◊ While families present with unique needs. Generally, family needs depend on whether they are new to the mental health system or not.
- ◊ New families struggle with stigma and denial of illness in the beginning stages and have a greater need for support and counseling through the mental health system.
- ◊ Experienced families have more of openness to accepting that there is an existence of a mental illness in the family but may have sense of despair and hopelessness.

### Needs of Families:

- ◊ Level of education and understanding of the western culture
- ◊ Family dynamics and the relationships among the family members.
- ◊ If the family is new to Canada their particular needs would include: immigration, social services, health, housing, legal, educational etc.
- ◊ Extent of their knowledge and ability to access services within the mental health system in Canada.

### Family Members:

The definition of a family member in the Somali culture is more encompassing than the definition of the mainstream Canadian culture. In Canadian society there is a fixed number of people who are assigned the definition of immediate family namely parents and their children. However, the definition of family in the Somali culture includes that of the Canadian definition as well as grandparents, uncles and aunts, cousins and other extended family. There is a distinct difference between the two cultures in terms of who is able to speak on behalf of relatives who are experiencing mental health problems. For example, in the Somali culture if there is a need for support for an individual in the mental health system, the responsibility lies on all of family members and not just the immediate family members.

### Important components of Somali Family Support/Counseling could encompass:

- ◊ One-on-one counseling for individuals or families who are dealing with family members with mental illness both short-term and ongoing.
- ◊ Support and counseling can be either on the telephone or in person in the office or in someone's home.
- ◊ It is generally the head of household of the family that reaches out to our services and becomes the lead for this particular family. This is generally the case for families with a child/youth with mental health issues.

- ◊ Advising families to care for themselves as well as their loved one who is dealing with mental illness.
- ◊ Cultural/religious counseling and expanding their support network among other Somali families and their relatives.
- ◊ Accompanying families to their scheduled appointments and giving them both emotional and technical support.
- ◊ Encouraging families to identify their most pressing needs and then prioritizing those into short and long term goals by using a family centered approach.
- ◊ Empowering approach for families is to assist them in guiding the process and being a support for their needs.
- ◊ There is a reluctance among Somali families to interact with professionals and clinicians within the mental health system and our support services then become a tool to encourage and assist them connect /work with hospitals, psychiatrists, nurses, family physicians, case managers, lawyers, CAS workers etc.
- ◊ Validate and value the family members as significant caregivers and substitute decision makers if assigned or needed.
- ◊ Educate families about their rights and responsibilities as family members.
- ◊ Confidentiality and consent issues are explained in more detail to the families so that they are better equipped to handle the decisions for their family member.
- ◊ Empowering families to demand respectful and dignified treatment from mental health service providers and professionals.
- ◊ Sharing with families strategies for stress reduction.
- ◊ Counseling and support is slower in the beginning because of the Somali cultural challenges with viewing members outside their families as intruders.
- ◊ Families will refuse counseling and support at some point and be prepared to accept their decisions.

## Challenges of Supporting and Counseling Somali Families:

- ◊ Home visits bring about a sense of intrusion for families by someone whom they identify as a stranger. (outside the extended family circle)

- ◊ As a counselor it is natural to become very involved with the problems of families and this may make it difficult to maintain boundaries. As a member of the Somali community it is easier to relate and connect with the experiences of families.

- ◊ There are cultural/religious barriers to women and men being supported by the opposite sex even when both are Somali. Differences in clanship may arise whereby some families may not be comfortable to accept support/counseling from counselors who are from a different clan. Some may object to Somali mental health support counselors and others that they know and prefer to have non Somali counselors.

- ◊ As a counselor there are times that your strategy for presenting information will change according to the audience and their perspectives. For example, if your audience is senior men who are spiritual and religious leaders, if you are a female counselor, the most

appropriate way to receive them is to dress accordingly. Make sure that you are modestly dressed and present yourself in a culturally appropriate way.

◊ There is a belief among some community members that counselors are guided by the salaries when attempting to contact clients for updates and support. This has its downfalls in that counselors might be discouraged from continuing to support families when there is an underlying assumption that counselors need the service.

## Strategies:

◊ Give information to clients that this service is offered by a program and it is not a fee for service.
◊ Express genuine feeling that you have to support and guide these families through a very difficult time.
◊ Clarify to family members that they continue to have the choice to remain with Somali counselors or request to be supported by a counselor from other mainstream agencies.
◊ Maintain clarity of boundaries as a professional and to have a code of conduct which guides you and your work as a counselor.

## Section #6 SOMALI FAMILY SUPPORT GROUPS

Support groups are currently a difficult and foreign concept to the Somali Canadian community and this makes it difficult to run a support group within those families that are dealing with mental illness.

Through public awareness and education there will be a process of acceptance and acknowledgement that support groups are an effective tool for families and individuals dealing with mental illness.

This process may take a while and may even have a lasting impact on the community and alleviate the sense of mistrust of the process and end results.

### Support groups will have possibilities if and when:

- ◊ The mental health family support program becomes a permanent program and has given the community a sense of continuity and trust that it will be there for them when their needs are magnified.
- ◊ The community has received enough awareness and education about mental illness and begins to understand the impact that this has on the individual, family and the community.
- ◊ Eradicating the stigma and sense shame that are attached to mental illness within the Somali Canadian community and this will possible only with a consistency in funding and resources for community agencies.

### Challenges:

Existing challenges for individuals and families to become a part of a support group are real and are similar to those challenges faced by low income families within the Greater Toronto Area.

- ◊ Single parent homes with very little time to spare
- ◊ Childcare
- ◊ Eldercare
- ◊ Transportation
- ◊ Shift -Work
- ◊ Value of support groups is not yet accepted by Somalis
- ◊ Naming of support groups could become a problem especially when outreaching to the Somali community.

### Systemic challenges include but are not limited to:

- ◊ Lack of culturally competent services in mainstream mental health agencies
- ◊ Systemic racism and discrimination
- ◊ Limited resources and capacity of Somali services providers to serve community members effectively and efficiently.

## Best Practices #7 Needs of the Somali Canadian Community

Collective trauma from experiences of the Somali civil war has a huge impact on many of the refugees who have come to Canada as a refuge. The multiple stressors within the lives of Somali Canadian refugees have resulted in the feelings of isolation and lack of support and counseling which prolonged the psychological trauma. The need of the Somali refugees in terms of counseling was not addressed from the beginning of their arrival and now there is a rise in mental health issues.

### Challenges

Racism and discrimination is a key challenge for all African Canadians and Somalis have experienced the affects of racism within the immigration, education, social services, employment and other areas of life. This is a key factor impacting the health and well being of all families particularly newcomer refugees and immigrants. This is particularly significant in the lives of Somali children and youth who have a very high rate of drop outs from schools in the Toronto District School Board (a policy oriented body e.g. School Safety, Zero Tolerance). This also shows in the high rate of delinquency among youth and their struggle with the criminal justice system.

### Lack of Resources

Somalis have come to Canada as refugees fleeing from war and violence in Somalia. They arrived in Canada without any of financial capital that immigrant communities bring as assets to support their families and community. These economic and social disadvantages have created a community that struggled to survive for their basic needs like food and shelter.

Another barrier is the lack of employment opportunities for both adults and youth and could be seen as one of the multiple stressors that could have possibly caused high levels of depression and anxiety. Lack of formal education of many, accreditation of foreign strained professionals and lack of Canadian experiences are three of the most obvious and most challenging barrier faced by Somali refugees in Toronto.

### Lack of Cultural Competence

Lack of cultural competence within mainstream agencies created barriers for Somalis particularly within the health, education and social services environment.

### Lack of Appropriate Housing

Somali families are traditionally large in number compared to the average Canadian families. When Somali families arrived in Canada they came with a number of children ranging from 5 to 10 children. This became a challenge for large families to find appropriate housing support services provided by the city of Toronto. This created obstacles for families to adequately support their children and created additional stressors for both parents and children. Living in public housing in areas around the city did not help the health of this newcomer community.

## Section #8 NETWORKING STRATEGIES

NETWORKING WITHIN THE SOMALI COMMUNITY

MEETING BETWEEN SOMALI FRONTLINE STAFF & SOMALI PSYCHIATRIST

One approach of networking was to set up a meeting between the only Somali Canadian psychiatrist practicing in Toronto and the Somali mental health counselors, case managers and other frontline staff. This meeting was initiated by the family mental health support program for Somali families which is a partnership between Midaynta, Somaliland Canadian Society of Metro Toronto and Family Outreach and Response Program. The main objectives of this meeting were as follows:

- Networking opportunity for Somalis working with the mental health system in the Greater Toronto Area.
- Creating strategies for long term sustainability of mental health program and accessing further sources of funding.
- Establishing a working relationship between the Somali psychiatrist and Somali frontline staff working in mental health services.

The Somali Psychiatrist indicated that "Denial" is the main obstacle/barrier to accessing services for Somalis living with severe mental health problems and their families. This is normal human response to trauma for most illnesses particularly those illnesses that are seen as fatal or without any treatments. He also mentioned that often the process of grief for individuals and families has three stages; Denial, Grief and Acceptance. Somali families are often destroyed by the grieving process and do not move on to the next step of acceptance of the mental health problem and finding ways to support their family member.

Lack of cultural competence within the mental health service practitioners in mainstream agencies, in addition to language and cultural differences, further complicates access to mental health services for Somali families. Overcoming this barrier is one of the most important challenges for community members and Somali mental health counselors and advocates.

Strategies:

- ◊ Creation of a *Somali Canadian Mental Health Support Network*
- ◊ Priority is for the Somali frontline workers to work together as a team. And create a format/formula for that working relationship
- ◊ There should be a consistent effort for frontline workers to network and share experiences and learn from each other by using case studies while respecting privacy of families and individuals.
- ◊ Case studies may be shared and used for public education and awareness building among the Somali community in Canada.
- ◊ Continue to search for funding opportunities to extend this program and its services.

NETWORKING IN MAINSTREAM AGENCIES

- ◊ Getting involved in Family Support groups within the city of Toronto and other agencies working in the same field.
- ◊ Memberships in committees and interagency networks within the mental health services and particularly within the family support programs
- ◊ Peer Support opportunities for information and guidance.
- ◊ Cross cultural training for mental health service providers.

## Section #10 Recommendations for Future Mental Health

From the work that the Somali Family Mental Health Support Program has done in this area, these are issues that need to be addressed:

- ◊ Requesting full time staff for the program is crucial to the success of the Somali family mental health support program.
- ◊ To make this family support program permanent so that the community can depend on it for continued support for families and to disseminate information.
- ◊ Expand the Somali family support program to the rest of the community with a specific focus on the needs of women, children, youth and seniors.
- ◊ Provide extensive training and support to staff and their education development.
- ◊ Placing permanent mental health counselors within the Somali service agencies to assist people with their questions regarding mental health services and medication etc.
- ◊ Encourage and identify Somalis with expertise in mental health and issues within the Somali community. Somali psychiatrist specializing in children and youth to be more involved in community activities regarding youth with mental health and addiction, homelessness etc.
- ◊ Gather information about all Somali frontline workers in the city of Toronto and disseminate that to the community.
- ◊ Involve Somali mental health workers in collaborative work and sharing of experiences and information.
- ◊ Create a Somali Canadian Taskforce on Mental Health
- ◊ Initiate a Somali Canadian Mental Health Support Network
- ◊ Continue in the area of research among the Somali Canadian community and its experiences with mental illness and the mental health system. Some of the areas of research can be in teen suicide, depression in seniors and women.
- ◊ Research in the area of connections between CHAT and mental illnesses
- ◊ Early intervention programs should be put in place as a long term prevention strategy
- ◊ To establish a health promotion programs aiming to prevent diseases in the Somali language for the Somali community