Why 'Mental Health' is not working: A case study of Somali refugees in New Zealand

Pauline B. Guerin, Roda Omar Diiriye & Bernard Guerin

University of Waikato

Psychology Department and

Migration Research Group

Kindly supported by the Foundation for Research Science and Technology as UOWX0203
Strangers in Town: Enhancing Family and Community in a More Diverse New Zealand Society

Somali Mental Health Brief Key Findings

- Heavy reliance on GPs alone and no interpreters
- Difficulties accessing specialist services
- Delays between ‘onset’ and treatment
- Did not understand drug prescriptions
- Traditional treatments and conceptions not explored
- Strong focus by professionals on war trauma and PTSD as the *cause* of “mental illness”
- Strong focus by clients on family separation and poor life situations as *cause* of “mental illness”

Problems seen by Somali with mental health services (1)

- Not being referred
  - Not being able to communicate needs (language barrier)
  - No awareness of needs and the possibility of treatment
- GPs prescribing anti-depressants
  - GPs prescribe 86% of antidepressants in Australia
  - Our research is planned to find out more on this
- Long waiting lists in mental health treatment
- High professional turnover

Problems seen by Somali with mental health services (2)

- Go to a therapist and sit in an office and 'talk'—a very unusual situation for them, and not seen as very helpful
- Lack of knowledge by professionals about refugee, Muslim and Somali backgrounds
- Communication gap
  - Many Somali don't understand their medications, what they are for, possible side-effects & what to do if they occur
  - Do not understand who is helping when and what for (e.g., the difference between a social worker, a nurse, a psychiatrist, a psychologist)

Implications for Changes (1)

- Improve referrals and access to specialist treatments
- Improve drug prescription and follow-up services
- Improvements on interpreting services

- All of these are badly needed because they currently lead to frustrations and negative attributions by all concerned
  - professionals, clients and interpreters

Implications for Changes (2)

- Better consideration by professionals of traditional views and treatments for “mental illness” and incorporation or facilitation of these into western treatments
- More Somali participation to develop mental health services that are relevant to them beyond having just interpreters present

Implications for Changes (3)

- Professionals need to spend more time in situ (in the community) rather than just a city office
- Professionals need to learn more about the families and communities involved in their ‘case loads’ and how conflicts arise from the social structures
- Professionals need to take on ‘advocacy’ roles as well

Could be part of wider changes

‘Alternative’ Views have a long History

- Bleuler (early 1900s)
- Thomas Szasz (1960s)
- Patrick Bracken (2000s)
- Richard Bentall (2003)

‘Western’ versus ‘Alternative’ Conceptions of MH

- Medicalised
- Biological
- Mediational
- Individual functions
- Pathologising

- Holistic
- It is what it is
- Social functions
- The organism is always right

‘Western’ versus ‘Alternative’ Treatments

- Talking Therapy
- Cognitive Behaviour Therapy
- Medication

- Massage Therapy
- Physical Activity
- Religious or Spiritual Approaches
- Diet and nutrition
- Relaxation and sleep improvement
- Art therapy
- Occupational therapy

Case Examples 1

- 28 year old Somali woman presents to GP concerned about excessive weight gain. Client speaks English very well and is a tertiary student.
- GP prescribes anti-depressants.
- Bodyweight and eating habits are not discussed.
- No follow-up or management is provided relating to anti-depressants.

Case Example 2

- 36 year old Somali woman complaining that she is confused and doesn't feel well. When asked what medication she is taking she presents a grocery bag full of anti-depressants, anti-psychotics, ulcer medication, panadeine, and allergy medication. When asked what each is for, she replies that she doesn't know.
- One week after stopping all medication, under medical supervision, (except ulcer medication), client is lucid and doing well.
- Client had been referred to MH services but missed appointments and was refused further referrals. Husband recently divorced her, leaving her with 5 children. Sister recently killed in clan conflicts in Africa. Elderly mother phones often from Africa needing assistance which client finds very stressful.
- Client speaks only a little English and has little education.

Case Example 3

- 22 year old newly arrived Somali woman complains of not sleeping and family conflicts. Client speaks English well and enrolls as a tertiary student at a local institution. Psychiatrist prescribes anti-depressants along with CBT.
- Through therapy it is revealed that her ‘family’ did not know of her existence as she was the daughter from an affair her father had with her mother. While the family try to welcome her, the relationships are strained.
- CBT, medication, physical activity and continuing her education all result in improved quality of life for this client although family relationships continue to have problems.

A drink of water…

- *“If I am walking all day and I come to you, I need a drink of water, you give me a drink of water, not ask me about the problem. They ask me to talk about the problem, talking, talking, talking about the problem. Always asking me about the problem.*

  Just give me a drink of water.”

    - *Rahma, discussing the problems with MH and Social Work service providers.*

Conclusions

- Mental health services for refugees need to be:
  - Specific
  - Inclusive of both Western and Alternative approaches
  - Ethnic-informed
  - Inclusive of advocacy services
  - Intersectoral
  - Family-focused
- Is what we are learning from “cultural issues in MH” telling us more about bigger theoretical issues in MH?

Why ‘Mental Health’ is not working: A case study of Somali refugees in New Zealand

Pauline B. Guerin, Roda Omar Diiriye & Bernard Guerin
University of Waikato
Psychology Department and
Migration Research Group

Kindly supported by the Foundation for Research Science and Technology through UOWX0203,
Strangers in Town: Enhancing Family and Community in a More Diverse New Zealand Society