Muslim Mental Health Matters

Steps to Recovery

Support for Community Champions

UK Muslim communities and mental health services: understanding barriers and gaps in support provision

December 2021

Report by:

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Civil Society Consulting

SFI Strengthening Faith Institutions

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Contents

1. Foreword

The Lantern Initiative is a Muslim-run grassroots social enterprise. We have been working to educate and raise awareness of mental health issues in the British Muslim community for the last 6 years. As a team made up of volunteers with lived experience of many of the mental health issues we work with, we feel impassioned about bringing Muslim mental health to the forefront for our communities.

Our grassroots work with local communities has brought us in contact with many individuals and families who are experiencing an ongoing struggle with their mental health and do not feel adequately supported; whether this is a lack of support from within their own families and communities or externally from statutory services. We feel strongly about listening to people and what their needs are. We seek to empower communities from within by enabling access to mental health education, support and self-help strategies. The rise in Islamophobia in the UK over the last few years coupled with the difficulties of Covid has meant British Muslims are struggling now more than ever, which serves to highlight the need for this work today.

We feel honoured to have collaborated alongside Muslim academics who are passionate and invested in using their academic skills for the Muslim community; this collaboration brings in both the richness from grassroots community work and academia to produce a report that looks at the mental health of the Muslim community in a more holistic and community-centred light. We feel it important for our work to be accessible to all, including those working closely with and supporting our communities in voluntary, charitable and other essential capacities. With this in mind, the report has been condensed succinctly to increase ease of access whilst providing clarity in the richness of data captured.

We feel it vital for policy makers, commissioners of health services, our communities, mental health organisations and faith institutions to work together and to think creatively about opportunities for collaboration within the area of Muslim mental health.

May God facilitate ease, goodness and healing for all. Ameen.

Safura Houghton
Managing Director
The Lantern Initiative CIC

2. Endorsements

"The Muslim Mental Health Matters report demonstrates the urgent need for approaches to mental health and wellbeing services that take seriously the centrality of faith and spirituality in the way that Muslims need to heal and build resilience. For too long the importance of embracing the spiritual in what we refer to as "mental health" has been undervalued and downplayed to the detriment of the Muslim community. The Islamic tradition offers a vast resource for health and wellbeing that stands not only to provide help and solace to many suffering but to help bridge the gap in the uptake of mental health services by Muslims. This report makes it clear that the time is now for pragmatic support and resources to be allocated toward the initiatives already underway to further develop faith-based support services for the psychological, emotional, physical, social and spiritual health of the Muslim community in Britain."

Dr Abdallah Rothman
Principal of Cambridge Muslim College and Executive Director of the International Association of Islamic Psychology

"While the world's celebrities and sports icons openly talk about their mental health post-Covid, this powerful report shines The Lantern Initiative's light on the social, cultural, and political forces that keep Muslims hidden and locked out from accessing the services they so desperately need. High rates of unreported depression and suicide reflect the real-life impact of the triple whammy of the prejudice of Islamophobia, the cultural taboos of honour and shame, and the isolating effects of poverty and caring. This report clearly shows how this nexus of gendered, raced, and religious inequality comes together to overwhelm some of the poorest and yet most put-upon communities in the world. These proud, hard-working, faithful communities are the backbone of the fastest growing and most productive group in Britain yet receive the least support and recognition for the work they do and the personal price they pay doing it. The Lantern Initiative report is a beacon of hope for the Muslim community and a wakeup call for the wider British mental health and wellbeing services."

Professor Heidi Safia Mirza
Professor of Race, Faith and Culture
Goldsmiths College, University of London

"The most comprehensive survey and analysis of Muslims and mental health that I have come across. Its findings should greatly help those seeking to improve therapy services. The report makes clear that significant changes, both conceptually and practically, are needed with statutory services, to meet the mental health needs of Muslim, and probably other cultural minorities; including taking more account of indigenous ways of defining mental health."

Professor Rasjid Skinner
Consultant Clinical Psychologist
Clinical Director - Ihsaan

"It's common to see mental health spoken of as an individual 'problem', divorced from social and historical context. This is an approach that is especially problematic when used to understand mental health in relation to groups who are structurally marginalised and discriminated against. Differently, and refreshingly, Muslim Mental Health Matters pulls no punches in naming the impact of persistent structural and systemic racism and Islamophobia on mental health for many Muslims in the UK, and in showing how intergenerational trauma of migration and colonialism live on into the present day, shaping (mental) health disparities and inequalities. Drawing on findings from a survey led by The Lantern Initiative, the report shows that experiences of othering and fear are common for many Muslims in the UK at a societal level but also within mental health services. Where services are available and accessible they are mostly Eurocentric in their design and may actually reproduce trauma. The report's findings are significant across multiple layers of service design and delivery, and have clear and resounding recommendations for the importance of decolonised, properly resourced, confidential, holistic, faith-based and trauma-informed provision, and for the re-imagining of both formal and informal safe spaces for Muslims experiencing distress. This should be widely read and its recommendations properly actioned in meaningful participation with Muslims who experience mental distress and or have contact with mental health services."

Dr China Mills
Senior Lecturer in Public Health
Programme Director - Masters in Public Health (MPH) City, University of London

'We're delighted to see that the fundamental research into Muslim mental health and wellbeing is being undertaken. There is a growing understanding and appreciation of mental health but there can always be more done to support British Muslim communities, across generations."

Aziz Foundation
(The Aziz Foundation is a family charitable foundation that works towards improving access to postgraduate education for British Muslims)

"The Lantern Initiative's report 'Muslim Mental Health Matters' once again raises important issues regarding the mental health of British Muslims with recommendations for the way forward. An interesting and timely report following a nationwide survey on the accessibility and attitudes of British Muslims towards mental health services.

As one of the first organisations to address the issue of British Muslim mental health in mainstream services, An-Nisa Society are delighted that this work is continuing and support the work of The Lantern Initiative in this regard. This is a priority and insha'Allah all professional efforts to take this forward is a step in the right direction."

Khalida Khan
Director, An-Nisa Society

"The Divine Revelation has at it's core the deliverance of humanity from alienation. Alienation of the Divine and alienation of the human spirit. As faith communities recognise the intrinsic link between faith, spirituality and mental wellbeing; the report from The Lantern Initiative is a welcome initiative to provide insight in this area. We hope that a holistic approach will better enable the Muslim community to address this most fundamental need for human spirituality."

Shaykh Muhammed Zaqir
Founder and Director - Darul Arqam Educational Trust Leicester

"This research and report come at a very timely juncture when there is significant need to mitigate the inequalities that prevail in ensuring mental health support provision in many of our faith communities in the UK today. This report will inform and influence change in policy and practice to improve the health and wellbeing of the Muslim community. It is a call to action, for communities, policy makers and practitioners - one we must collectively endorse and enact."

Dr Mehrunisha Suleman
Center of Islamic Studies, University of Cambridge

"This survey report helps towards filling a research gap and a much needed addition to the evidence base on understanding the mental health needs of a growing Muslim community across England. The findings and recommendations of this work should inform the work of national and local policy makers and commissioners of mental health services, supporting them to reduce stark inequalities faced by Muslim communities".

Nuzhat Ali
National Public Health Leader - Department of Health and Social Care
Co-Chair - Civil service Muslim Network
Advisor to Inspirited Minds

"It is understood that many suffering from mental health issues are stigmatised and the subject remains one of taboo in Muslim communities. However, little is known about which provisions are most needed and how they can be made more effective from a faith perspective for those suffering. This report takes an important step towards enabling practitioners, commissioners and community organisations to inform the development and delivery of interventions which support the mental well-being of Muslims in the UK."

Rizwan Yusoof
Director of Services
National Zakat Foundation
(NZF collects and distributes Zakat to Muslim communities across the UK)

3. Executive Summary

In June 2021, The Lantern Initiative launched a national survey to inform their own mental health support provision. Additionally, the aim was to provide a resource for other Muslim-focused mental health organisations, faith-based counselling organisations, mosques and Islamic centres, as well as clinical commissioning groups.

The survey aimed to understand:

- the needs and views of the Muslim community relating to mental health;
- the barriers to accessing mental health support;
- what is working in current mental health provision and what is not; and
- the gaps in mental health provision, and what opportunities there are for improvement.

It was anticipated that this understanding will inform mental health support providers in relation to:

- Improving the delivery experience of current services.
- The commissioning of new programmes.
- Making support more accessible to Muslim communities.
- How different support ecosystems can work together.
- How to engage with the Muslim community on mental health topics.

This report collated findings from **926** survey responses, reporting on common themes relating to contextual factors (see Section 3) and key findings. A number of key findings have been translated into a series of evidence-based recommendations. Aaliyah Shaikh (PhD researcher in Health Psychology at City, University of London) and Rahmanara Chowdhury (Lecturer in Islam and Pastoral Care at the Markfield Institute of Higher Education) provided insight into the survey findings from their perspectives as mental health researchers and as practitioners in Muslim communities.

This report was produced with the support of Civil Society Consulting CIC through their Steps to Recovery programme in partnership with Strengthening Faith Institutions - an interfaith initiative of Ostro Fayre Share Foundation.

Below is a summary of the findings, organised under the key themes identified from the responses.

Faith-based counselling

In relation to how faith-based counselling provision was perceived, both barriers and enablers were expressed.

Barriers to accessing faith-based counselling services were identified as:

- Imposition of negative connections, e.g. implying poor mental health is a reflection of poor faith.
- Lack of availability.
- Concerns in relation to professionalism, confidentiality, and training adequacy.
- Concerns relating to whether the approach would be too narrow and not sufficiently holistic.
- Poor service quality.
- Lack of inclusivity for further minorities within minority communities such as those with disabilities (and not forgetting those with invisible disabilities) as often experiencing a complex intersection of triple or multiple minority status.

Enablers to faith-based counselling were put forward as:

- When it worked, it was identified as a positive experience.
- **69%** said they would recommend faith-based counselling.
- Better understanding and integration of cultural and religious sensitivities.
- Faith was viewed as an important aspect of life, healing, health and wellbeing.
- The integration of spirituality within addressing mental health was viewed as offering a more holistic approach. Faith-based counselling was sometimes viewed as a bridge to accessing other forms of mainstream and clinical support.

Cultural attitudes to mental health

Ideas, social customs and behaviours that communities normalise and understand often define how they experience, interpret, and act upon mental health issues. Cultural factors can determine how much support someone gets from their family and community when it comes to mental health. Our respondents shared what this meant for them:

- Mental wellbeing was regarded as being just as important as physical wellbeing by **99%** of respondents.
- Desiring a better awareness or understanding of mental health was expressed by **84%** of respondents.
- Learning about mental health through more interactive methods was preferred.
- Online resources were the most preferred means of accessing mental health resources.

Impact of Covid-19

There were a mixture of feelings expressed in relation to the impact of Covid-19:

- Negative impacts of Covid-19 were deemed to have contributed to an increase in stress and anxiety, an increase in loneliness and isolation, and an increase in sadness, depression and grief.
- Positive impacts of Covid-19 were expressed as increased time for self-reflection, time to spend with family, and increased time to pursue personal interests.

Counselling trends and experiences

Trends in the types of counselling services accessed were revealed:

- Of the respondents, **48%** had previously accessed counselling services whilst **50%** had not. The remaining 2% did not answer.
- The three most accessed counselling services were as follows:
    - NHS (GP referrals / IAPT) accessed by **52%** (60% deemed the service as being effective).
    - Private fee paying counselling accessed by **42%** (80% deemed it as being effective).
    - Counselling through mental health charities or support organisations was accessed by **21%** (59% deemed it as being effective).

Barriers to accessing support

Barriers to accessing support revealed the following:

- Significant impediments to accessing support related to perceived social stigma. Respondents feared being judged negatively by others if they accessed mental health support.
- In seeking to access mental health support, the following were expressed:
    - Lack of support from families was indicated by 55%.
    - Not knowing where to go for support was indicated by 38%.
    - Questioning the existence of mental health itself and comments undermining one's own mental health concerns were expressed by 6%.

Mainstream Counselling

In relation to how mainstream counselling provision was perceived, the following were expressed:

- The desire for faith informed counselling services was expressed by **84%** of respondents.
- It was felt by **44%** of respondents that current mainstream counselling provision did not cater to needs relating to faith issues.
- **53%** of respondents felt that NHS waiting lists were too long.
- There were greater levels of trust expressed regarding the professional level of training undergone by those within mainstream counselling provision, than there were for faith-based provision. The widespread availability of mainstream provision was seen as an enabler to accessing counselling services.

Mental health support from Mosques and Islamic Centres

Within a faith institutional context, barriers to accessing services were specified as:

- Concerns surrounding confidentiality.
- Concerns about being judged negatively.
- A lack of knowledge and awareness regarding mental health services.
- Concerns in relation to whether such practitioners would be professionally trained to adequate levels.
- The lack of inclusivity and accessibility of such services.

Enablers to accessing services within a faith institutional context were put forward as:

- Sources of informal support as primary options.
- Formal counselling following on from accessing informal support.
- Presence of support groups within mosques.
- Effective use of signposting.
- Spirituality classes providing added elements of softer sources of support.

4. Context

The following section provides context as to why mental health support and mental health awareness-raising for and within the British Muslim population requires investment and improvements, and is the rationale for why this report was commissioned.

The 2020 census puts Britain's Muslim community at some 3.4 million, which makes Islam the second largest faith group in Britain, after Christianity. Despite constituting such a large part of UK society, many Muslims feel 'othered', different, separate as well as fearful - they are also more likely to experience direct discrimination [1] and inequalities as a minority and otherised group, which can affect one's sense of self and experience of the world. This can lead to a variety of issues including, but not limited to: confidence struggles, low self-esteem, work-related stress, anxiety and other mental health strains.

Cultural ideas around mental health and coping compound these factors, and ideas about how one should cope can act as a barrier to accessing mental health support. In some cases and communities, there is significant stigma attached to mental health issues, which leads to a denial of its existence. There are multiple compounding factors that create added vulnerability in marginalised communities, in this case the Muslim community. This increases the chances of predisposition to mental health distress and psychological disorders. One of these is the trauma of being a largely migrant community, having been deeply colonised, and the resultant ongoing intergenerational impact, health disparities and inequalities [2].

The British Muslim community is largely made up of a South Asian population [3] who are less likely to access mainstream mental health services [4]. There is a propensity to deny mental distress until it can no longer be contained within family, community or religious networks. For some there is also a feeling of just not knowing what to do or where to go for help. Ethnic minority groups have traditionally been under-represented in voluntarily-accessed mental health services [5] such as talking therapies, while over-represented in non-voluntary services like in-patient care under section, despite government targets to change this.

Adding to the argument, there is some anecdotal evidence that rates of depression are higher in the British Muslim community than the general population, and that Muslims are less likely to seek treatment. However there needs to be a wider discussion in our communities about the issues we bring to the table so that we can more appropriately respond. The research in this area remains scarce therefore a conclusive statement cannot be drawn.

One of the major difficulties in this area is the lack of investment, funding and resources to carry out research on British Muslim society that goes beyond stereotypical tropes, for example the constant gaze on Muslim women's attire and extremism.

Marginalised communities do not often have an 'evidence base' in the same way to argue for their needs and appropriate interventions and practices - usually because there is not enough interest and funding to carry out research in these communities in the first place. There are discourses that critique the status quo of the 'evidence base', (over other forms of knowing and doing) which can reinforce stigmas and existing structures of power. This results in missing important alternative approaches and practices that can be facilitative, engage communities and improve health outcomes. Even if there is research, very few from within marginalised communities are ever involved in research design, analysis and interpretation of data. If research is carried out, it is often through Global North Eurocentric secular perspectives which can be laden with projections, cognitive bias, and a lack of nuance. This means that important findings can be missed, because the right questions are not asked and power structures at play are not acknowledged.

There is not equitable or equally available in-depth data on marginalised groups to be able to argue reform in mainstream institutions and wider society. Here we could reflect on the example of the National Indian Health Board (NIHB) based in Washington DC, who represent Tribal governments -"both those that operate their own health care delivery systems through contracting and compacting, and those receiving health care directly from the Indian Health Service (IHS)". They centre the needs of the community and work with the relevant health care providers and policy makers to ensure the communities needs and practices and ways of knowing are heard, inform policy and lead to improved health outcomes.

Relevant and appropriate mental health services need to be decolonised, and not just respective of but centring the intrinsic knowledge base of Muslim people. This can be done through consultation and empowering Muslim communities to contribute and inform policy making decisions, with considerations given to resourcing, support and co-creation.

There is a dire need for financial resources to fund research and commission community organisations. This will utilise and enhance resources and expertise already present within Muslim communities. In turn, this will create community ownership and engagement for research and provide valuable data often inaccessible to those with limited investment within such communities.

Muslims face a plethora of mental health issues like any community, be it depression, anxiety, abuse, grief, relationship issues, suicidal feelings - anything that affects the human condition. However, Muslims experience their own unique set of struggles and intersections which may compound these: being a largely migrant community, facing discrimination, scarcity, fear and othering, arriving from war-torn areas, as well as intergenerational, racial and Islamophobia based traumas. For example, one area which we were unable to explore in this study would be to look at how Islamophobia intersects with anti-Black racism, and how this impacts on mental health of Black Muslims. Furthermore, there is a need to acknowledge Muslim epistemologies: how Muslims' understand and relate to the world; how Muslims make sense of and give meaning to problems and the nature of the solutions being sought; the rich heritage of medicine and healthcare including mental health care; and the existence of unique traumas. In relation to this and any research carried out, it is crucial to be acutely mindful of how the historical and ongoing impact of colonisation of Muslim communities has and continues to have implications on health, mental health and health service provision, in addition to how Muslim communities are (mis)understood.

The following section provides context as to why mental health support and mental health awareness-raising for and within the British Muslim population requires investment and improvements, and is the rationale for why this report was commissioned. We would also like to emphasis that this report is rooted firmly in Muslim experiences (not to be conflated with 'ethnic minority' experiences, though these may intersect).

Historical trauma is understood to refer to: "a complex and collective trauma experienced over time and across generations by a group of people who share an identity, affiliation, or circumstance"[6]. This is particularly pertinent within a climate of discrimination, Islamophobia, race-based violence, and wherein established epistemologies are generally reflective of the Global North Eurocentric secular Caucasian communities. Furthermore, persistent structural and systemic racism and Islamophobia have a powerful impact on health disparities [7]. The very nature of it makes it deeply challenging if at times seemingly impossible to be heard by the very people who are in need at all levels and all sections of the community; be it service provision, healthcare providers working to enable services, those working at grassroots level to provide support despite multifactorial barriers or for communities to be represented accurately in health research.

Culture, marginalisation and identity

For Muslims, culture, marginalisation and identity [8] all play a huge part in their experiences of mental health issues. Prejudice, discrimination and stereotyping that the Muslim community often face can have a detrimental effect on mental health [9].

A recent report from The Better Community Business Network (BCBN) and the University of East London identified that many young Muslims who have experienced mental health struggles have been victims of Islamophobia and a large number of them have experienced bullying in school [10].

Stigma

Stigma is a significant barrier for Muslims accessing mental health support. For many Muslims, seeking help does not feel like a socially acceptable solution to tackling mental health issues due to the judgement and lack of understanding they may face from within their own families and communities. In some communities, there is denial about the existence of mental health issues or cultures of 'keeping it quiet' which makes accessing support informally and formally difficult and sometimes impossible, further compounded by additional layers of internal barriers.

Islamophobia, racism and discrimination
The prevalence of racism and Islamophobia in wider society are an additional barrier for Muslims in accessing mainstream healthcare [11]. There are 'circles of fear' between Muslim communities and public services that are powered by the 'othering' of Muslims by the media and government policy [1]. This results in a two-way fear. Studies of experiences of ethnic minorities in mental health services have concluded that discrimination is rife [12].

Furthermore, centering the significance and role of 'fear' in interactions as part of trauma aware care and community interactions is crucial in driving forward healing dialogues and practices.

While people are in a state of fear it is known that the human sympathetic nervous system activates the fight/flight/fear/freeze/collapse response system. It is virtually impossible to activate the rational thinking part of the brain until a feeling of safety is once again restored and sadly the absence of feeling safe keeps us in a state of chronic stress which leads to multiple health issues.

Lack of cultural awareness in mainstream mental health provision
Due to the eurocentric approach in the design of mental health provision, people from some ethnic minority communities struggle to access services [13] in ways that are meaningful and beneficial to them. Many Muslims do not seek mainstream support for various reasons, including that it is not faith and culturally-sensitive and therefore does not feel applicable to their lives. Often mainstream mental health service providers come across as insensitive to or ignorant of cultural needs [14].

Misunderstandings regarding mental health
British Muslim communities can view mental health concerns as stemming from a number of sources. For example, some feel that depression is not an illness, or will trivialise it. There are also misconceptions whereby mental illness is attributed to *jinn* (evil spirits) possession or the evil eye. There is a lack of education around distinctions between *jinn* possession, evil eye and black magic (*sihr*) and what may be mental, physical, physiological or psychological in nature. Unfortunately, sometimes misunderstood theology is used to perpetuate myths around mental health. These misunderstandings result in a narrow understanding of mental health conditions and may prevent individuals from seeking professional help.

5. Methodology

The survey

The findings from this report are based on an online survey conducted from June to August 2021, over a period of eight weeks. We collected both quantitative and qualitative data. In total, **926** individuals participated in the survey. The primary objective was to understand the experiences and attitudes of Muslim communities toward mental health support.

The survey consisted of 29 anonymous questions, with every question being optional to answer. We felt this flexibility was important due to the sensitive nature of some of the questions and to ensure people felt they had autonomy and control over which questions they answered, whilst having the option to have their voices heard. Despite the sensitive nature of the survey the community was extremely open and candid with their responses, for which we are extremely grateful.

The questions were devised by The Lantern Initiative in consultation with Civil Society Consulting (CSC). CSC had recently undertaken a piece of research for Mind, investigating the barriers to accessing mental health support for perinatal women in South East London. The survey design was informed by CSC's learnings from this study, and by The Lantern Initiative's experience and knowledge of issues around mental health in the Muslim community.

The Lantern Initiative consulted with two academics who specialise in Muslim experiences of Mental health - Aaliyah Shaikh (PhD Researcher in Health Psychology at City, University of London) and Rahmanara Chowdhury (Lecturer in Islam and Pastoral Care at Markfield Institute of Higher Education). Guidance was sought on the design of the survey and in relation to ethical considerations. After this initial consultation, both Aaliyah and Rahmanara supported us to analyse the research findings, advise on recommendations and provide editorial support.

Engagement methods

The survey was open to all Muslim adults living in the UK. The Lantern Initiative was tasked with engaging Muslim communities across the UK, for which they utilised their networks and social media reach to promote the survey, in particular Facebook, Twitter and Instagram. They created short engaging posts and film reels to raise awareness. Tweets and posts were shared by local and national organisations including Mind, Muslim Census, Mental Health First Aid England, Centre for Muslim Policy Research, Muslims in Britain Research Network, Roshni-2 Project, Emerald Network, Muslim Women's Network, Muslim Counsellor and Psychotherapist Network (MCAPN), Markfield Institute of Higher Education, and Muslim Youth Helpline. A number of individual therapists, mental health professionals and faith leaders also supported the distribution of the survey.

Limitations

Incomplete responses: due to the sensitive and personal nature of the survey, all questions were 'optional'. Using 'obligatory' questions may have caused respondents to prematurely end the survey when faced with a difficult question. Although this meant a potentially smaller sample size would be obtained for certain questions, it was deemed this would be appropriate in order to maximise engagement with the survey. This decision was backed up by a recent study by Décieux et al. [16], who showed that 35% of respondents dropped out of a survey when they were required to answer personal questions compared to 9% when they were allowed to skip questions that felt too personal.

Confirmation bias: we acknowledge that the methods through which the survey was distributed - The Lantern Initiative's networks are already engaged in mental health and wellbeing issues - hold potential for an element of confirmation bias in the survey findings. Despite this, the researchers are confident that the survey reached individuals outside of The Lantern Initiative's network (there were responses from Northern cities and towns, for example; the Wirral, Manchester, Oldham, Leeds, Preston, Bradford, Sheffield - where the organisation does not currently work).

Open invitation: the survey was distributed on social media, therefore we are allowing a very small error margin for respondents who do not fit our criteria. A very small number of survey responses came from non-Muslims (0.46%) and those residing outside of the UK (0.8%, n=7), which we consider insignificant.

Representation: a significant number of respondents were female (82%), whilst 18% were males. Therefore further representation within the Muslim male population is required. This is reflective of mainstream population groups where males generally engage less with mental health concerns. Furthermore, the sample consisted of a South Asian Muslim (71%) majority [1]. Although South Asians are known to be the majority ethnic group for UK Muslims, the Muslim demographic has undergone recent shifts and therefore requires further representation within future research. We acknowledge that our reach was limited in reaching specific communities. Despite being an online available survey that we tried to distribute as widely as possible there are inevitably people we were unable to reach such as those who do not have access to the internet and communities who are unlikely to complete surveys. We highly recommend further focused research that accounts for these differences in experience.

Terminology: Throughout this report we have included wording and terminology such as ethnic minority, BAME, disorders - we acknowledge that these are not the best or preferred terms by different people, however for the time being we have used these as commonly understood and used terms.

The term Muslim community has been adopted throughout, however, within this we recognise that there is no one singular Muslim community, rather there are many Muslim communities with shared similarities and differences.

1. For this report, we categorised South Asians as Asian or Asian British - Indian; Asian or Asian British - Pakistani; Asian or Asian British – Bangladeshi; Asian or Asian British

6. Demographics of survey respondents

n represents the sample size, or the number of people who answered this particular question on the survey.

99.5%

of respondents identified as Muslim (n= 651)

82%

were women (n=646)

18%

were men (n=646)

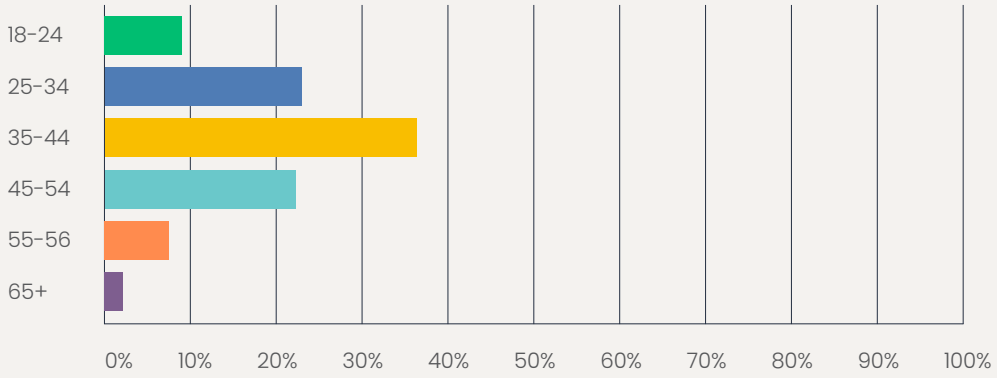
71%

identified as South Asian - the most common were Pakistani (39%), Indian (20%), and Bangladeshi (12%), 9% identified as White; 5% Mixed; 2.5% identified as Black and a small number identified as Arab (n=650)

The most common age bracket of respondents taking part in the survey was

35-44 (35%) (n=649)

Q22. "How old are you?"



27%

of respondents lived in London, however the survey attracted responses from all over the country

Q23. "Which area of the UK are you based in?"

7. Findings

In this study, we explored cultural attitudes to mental health, the effectiveness of several types of mental health support and the barriers British Muslims faced in accessing them. To present the findings in the clearest way, we have organised the findings into seven sections. For the section addressing different types of counselling, we have categorised it into 'enablers' and 'barriers' of access in reflection of the findings.

a. Cultural attitudes to mental health
b. The impact of Covid-19
c. Counselling: trends and experiences
d. Barriers to accessing support
    i. Social and cultural barriers
    ii. Individual barriers
e. Mainstream counselling
    i. Barriers
    ii. Enablers
f. Faith-based counselling
    i. Barriers
    ii. Enablers
g. Mental health support from mosques & Islamic centres
    i. Barriers
    ii. Enablers

a) Cultural attitudes to mental health

The survey asked respondents about their views on the importance of mental health and how open they were to learning more about mental health - the responses were extremely encouraging:

99%
of respondents felt that their mental wellbeing was as important as physical wellbeing.

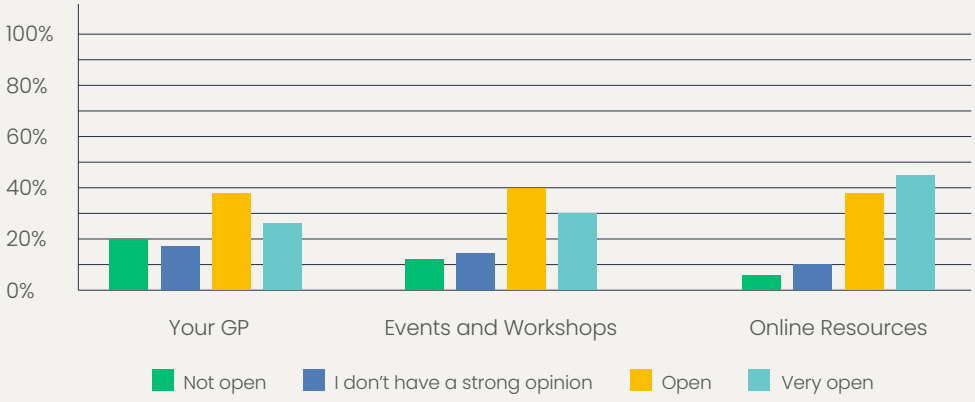
n=888

84%
of respondents would like to have better awareness or understanding of mental health.

n=873

Q4. "How open are you to access the following to learn more about mental health?"

n=811



Survey respondents were most open to learning about mental health through online resources which provided a greater sense of personal autonomy. This method allows learners to go at their own pace thereby facilitating greater flexibility and accessibility.

Learning about mental health through events and workshops ranked above learning about mental health through GPs. Within the comments, some explained that they felt that their GP was not well-equipped to deal with mental health concerns.

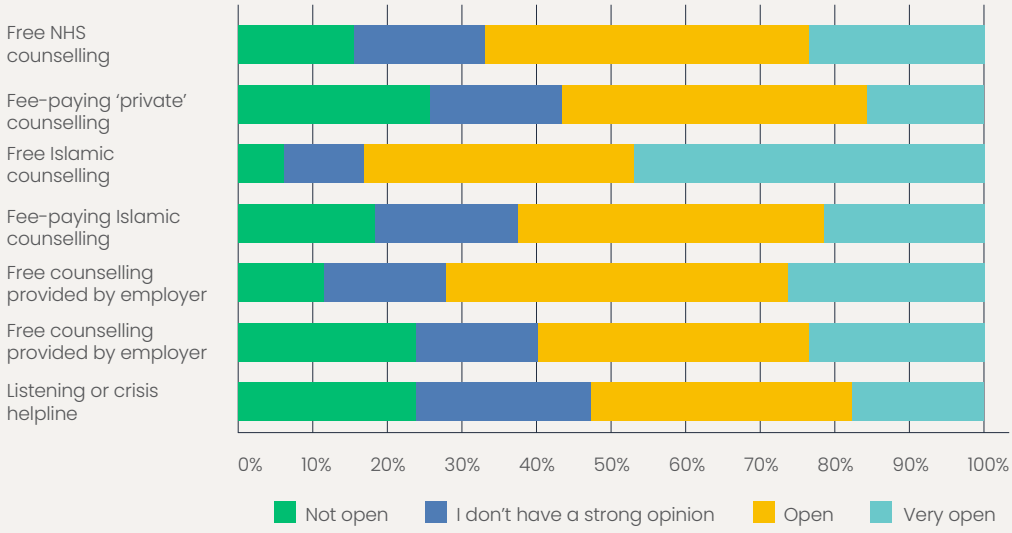
Other common sources through which respondents learnt about mental health included:

- Workplace wellbeing programmes
- Friends or family
- Books and magazines
- Other reading materials (e.g. flyers distributed at university or work)

We also asked respondents who had not accessed counselling before where they would be most open to access counselling from:

Q12. "How likely are you to access the following for counselling? You do not have to answer this qustion."

n=672



Free Islamic counselling was the most popular option (83% said they were 'open' or 'very open', followed by free counselling from a **charity** (72%) and **free NHS counselling** (66%). From this, we can deduce that cost is an important concern for accessing mental health support. When cost is not an issue, most people prefer to access counselling that is informed by faith.

Analysis
The strong desire for services to cater to faith-based needs was evident. This is reflective of a shift within the counselling sector whereby there is an increasing demand for the inclusion of (or return to) faith and spiritual identities within therapeutic work. This shift has already been present within other sectors for considerably longer, such as interventions within some elements of the criminal justice system. There has also been a long tradition of Christian based counselling and pastoral support in the UK. It is however evident that few mainstream training routes offer adequate training in how to cater for such needs.

Providers of such courses and training need to offer a genuinely more inclusive and decolonised curriculum that is willing to engage with, address and equip its students in being able to effectively provide services to those who may want to include their faith or religion in their exploration of mental health. Part of this would include being mindful and critical of their own potential role in, and addressing uncomfortable areas such as, potentially perpetuating social injustices through upholding and enabling structural and systemic processes or individual bias that are unjust, oppressive and harmful. Furthermore such providers could also cater for the needs of the Muslim therapist in training, allowing them to bring their 'whole' self to the shared learning space. This should occur without trying to 'rescue', change, or strip the person of their beliefs. Instead, open dialogue and using sources of healing from the Islamic tradition and understanding of psychology could offer a truly healing and restorative therapeutic experience. This raises questions in terms of private practice and ethical standards relating to such provision as well as a call to accrediting bodies and institutes to offer support and be inclusive of therapists who practice or include indigenous faith-based counselling, in addition to how demand can be met within the sector as a whole.

It was clear that addressing mental health concerns was a priority for Muslims. A clear willingness to engage with support services was present. However, it was also apparent that key factors were critical in facilitating such engagement - these factors included autonomy over access, flexibility in how and when such access could be utilised, the importance of privacy within this, and accessibility as a whole.

The way in which services are accessed is seeing a shift to online platforms, as per general trends. The danger of all services migrating to online only services however would be limiting access opportunities for those who are not familiar with or regular users of online environments. Furthermore, there is the issue and need for physical presence and social contact for many. There is a completely different dynamic to a face to face therapeutic encounter that missing out on could also be disadvantageous or detrimental. There is a need for a multi method approach for different accessibility options depending on need. Some people may not be able to physically attend or access certain types of services due to various reasons; such as disabilities, chronic illness, caring responsibilities, ill health, cost.

Further questions were raised in relation to making counselling services financially accessible for all. Finances were clearly a consideration in relation to accessibility. By having a cost attached for such services it can limit accessibility for some individuals in society. This requires urgent attention in order to ensure that individuals can benefit from timely support and are not prevented from accessing the type of service they require due to cost.

b) The Impact of Covid-19

The pandemic continues to play a significant role in our experience and awareness of mental health. We wanted to get a sense of how the pandemic impacted survey respondents' mental health and wellbeing.

Respondents overwhelmingly felt that the pandemic had worsened their mental health, due to a variety of factors, these are shared below:

Stress and anxiety: Many people reported feeling more stressed, anxious, and irritable. These were attributed to not being able to get out of the house, which related to or connected to a lack of space, not being able to get away from overcrowding or have time away from household members, and not being able to access outdoor exercise. Survey respondents also reported feeling stressed about finances and health issues.

"The lockdown definitely affected me by not being able to have a normal life, and to see my family and friends, which caused stress and anxiety."

Loneliness and isolation: Feelings of loneliness and isolation were common, as people were unable to see family, friends, and colleagues for extended periods of time. Some people also felt that they were losing connections with people they used to be close with, adding to their feelings of isolation.

"I can feel quite isolated and frustrated at the monotony of being home all the time, without the ability to socialise with work colleagues. There is fatigue at 'the same old'. As things open up, socially it's become so busy, it's exhausting."

Sadness, depression, grief: For many, lockdown created or exacerbated feelings of sadness, depression, or grief. People grieved for opportunities and plans that were no longer available, as well as for loved ones.

"Isolation has led to depression and high levels of anxiety. Not knowing what's going to happen next. Losing people to death and not getting to say goodbye. Freedom and being able to move about has left a big impact on my mental health because I had no one to talk to or meet."

However, some people also found that aspects of being in lockdown had a positive impact on their mental health.

Time for self-reflection: Some people mentioned that the lockdown gave them time for self-reflection and helped them become more in touch with themselves:

"Lockdown actually improved my mental health by allowing me to have time to myself and give myself the time and attention I needed which is quite rare..."

"It allowed me to access some memories and triggers I didn't know I had. This has allowed me to understand myself better and seek much needed guidance and advice."

Having more time to spend with family and pursue interests:

"It has allowed me to engage in so many gatherings and classes , which really boosted my purpose."

"It's a difficult situation, but nice to spend time with my children."

Despite the challenges that came with the lockdowns there was an element of growth for some. Time for self-reflection and sometimes being faced with stark realities that one was confronted with led to self-development and a recalibration.

Analysis

Whilst Covid-19 has clearly had an impact ranging from the individual level to the global level, the introduction of lockdowns has profoundly exacerbated that impact. Globally the scale of grief, isolation and loneliness, the experiences of deep loss, feelings of vulnerability and concerns over physical health have been naturally unprecedented. Given the scale of the loss of life and the degree of uncertainty on numerous levels, this is to be expected.

In addition to this, the primary concerns raised within this survey related to social connections and the damage caused by the imposition of lockdowns. For some, this resulted in complete isolation for an initial significant period of time, whether due to living alone or having no technological means or technological literacy. This isolation has continued to persist in various forms and to varying degrees as lockdowns have taken on new forms. Whilst this was a new challenge to all, the lessons learnt in relation to social contact must be taken heed of going forth. The structure of communities resulted in isolation to unprecedented levels. This requires examination in terms of provision at the level of local communities, in order to prevent harms relating to social isolation. The lack of funding for community development and enrichment opportunities which historically facilitated communities thriving collectively, is one such example. The long term ongoing impact on physical and mental health must not be forgotten.

There were feelings of stress, depression and anxiety which are all normal, natural and to be expected given the nature of what was an unexpected once-in-a-generation global shock. The situation had multiple consequences affecting people's sense of self, economic situation, creating fear and intense worry around basic survival needs being met, around food availability and lack of social contact, loss of loved ones; vicarious trauma was experienced by many. For those already experiencing mental health struggles these were exacerbated. There has been an adjustment period and for many this is not a linear process but one with ups and downs depending on multiple factors and the ongoing nature of the pandemic.

For those living in overcrowded or physically small households, the frustrations and challenges of not having enough privacy was evident. This again points towards the need to consider the diverse range of households and the highly tangible damage caused by a one size fits all approach. Whilst Covid-19 by its very nature initially provided minimal room for manoeuvre, consideration needs to be given to how poverty can be better addressed whilst some semblance of normality is attempted. This would endorse a preventative approach in relation to the exacerbation of further long term harm for those who have already faced the toughest challenges during this period. Whilst this would be belated, it is nevertheless necessary particularly considering the requirement to co-exist alongside Covid-19.

Social support can often take place in a variety of formats, sometimes so subtle they often go unnoticed. The spikes in mental health concerns nationally reflect the value of all forms of social support. The need for investment into social support through a variety of means is highlighted. Such means need to be able to function regardless of external circumstances and challenges. This would further help to alleviate some of the burden placed on the statutory sector.

The opportunity to utilise alone time and the reduction in distractions provided a time of growth and development for some. This was however dependent upon having an environment which facilitated this and was conducive to this. This draws into question basic standards of living for all. The nature of the essential services which continued to run during lockdowns demonstrated that those who often face the toughest working conditions are the very people the national economy and basic living standards depend upon. Yet they were also some of the lowest waged sectors, some with no protection at all by virtue of zero hour contracts. These individuals and families did not get such opportunities for growth and development. They have continued in their service to the UK whilst they have also continued to be the most penalised in society. Despite this, they continue to be the vital lifeline to the UK as a whole.

c) Counselling: trends and experiences

Encouragingly almost half of respondents **48%** said that they had accessed some sort of counselling, whilst 50% had not, and 2% preferred not to say (n=744).

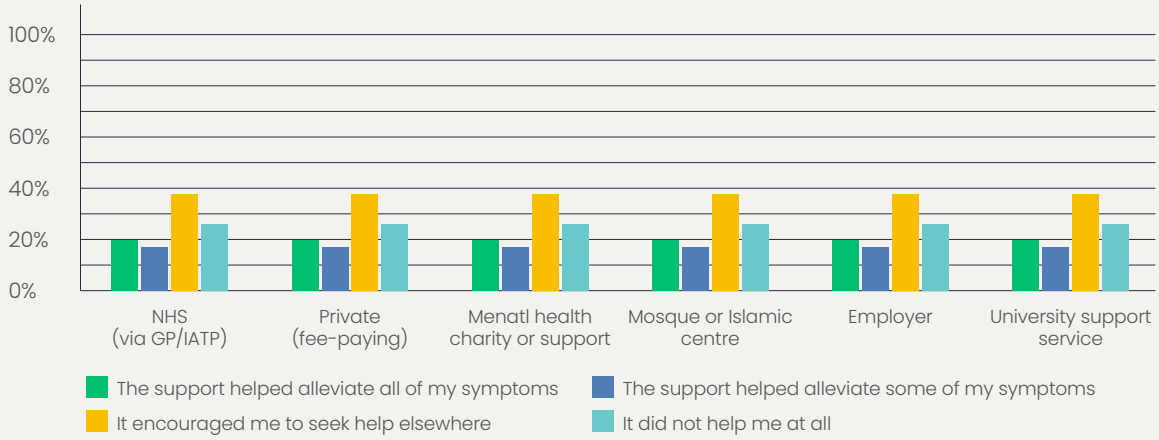
Of respondents who said they had received counselling, **52%** (n=361) did so through the NHS - either through their GP or Improving Access to Psychological Therapies (IAPT).

Private (fee-paying) counselling was the next most common way respondents accessed mental health support **42%,** followed by a mental health charity or support organisation **21%**. Smaller percentages of respondents received counselling through their employer or university - **13%** for both. Only **5%** of respondents said they had accessed support from their mosque or Islamic centre.

Respondents found private (fee-paying) counselling the most effective (n=361), with **80%** saying 'the support helped alleviate all of my symptoms' or 'the support helped me alleviate some of my symptoms.' The next most effective counselling option was through the NHS **60%**, followed by a mental health charity or support organisation **59%**. Again, counselling from mosques and Islamic centres were ranked least effective **28%**.

Q9. "What were your experiences of the support you received? Please only answer for the provider(s) which you have received counselling from"

n=337



Analysis

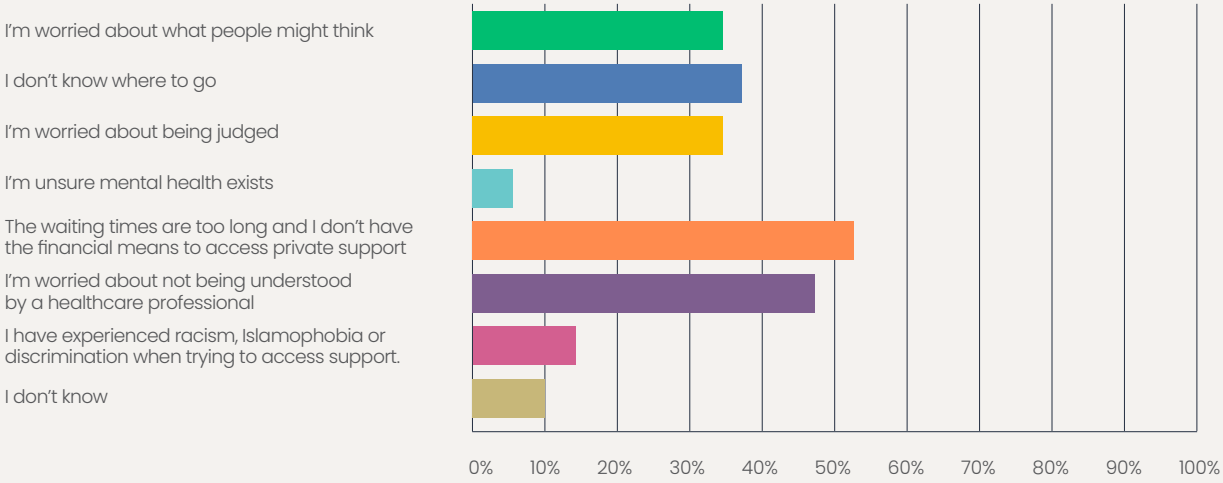
While most people expressed a preference for faith-sensitive counselling, the majority who had counselling in the past mostly accessed it via free NHS services (52%). Therefore, socio-economic factors played a critical role in people's ability to access mental health services and support. This was in tandem with a lack of availability and quality from faith-based providers. There was a distinct gap in faith-based mental health support, which, if embedded with the sector level of professionalism within mosques and faith institutions, would eliminate some of these accessibility barriers. Equally, there is scope for consideration of how such services could be better embedded within provision that is more readily available (private and NHS).

A noteworthy finding was in the comparison of perceptions between those who had accessed mental health support and those who had not. Those who had accessed mental health support used mainstream services more frequently and generally were more positive about them. Those who had not accessed mental health support said they were most likely to use faith-based and Islamic counselling, which did not reflect what was occuring in reality. This discrepancy could be explained by the lack of availability of quality free faith-based counselling services in the UK, given that cost came up as a significant factor in accessibility of suitable counselling services, whether mainstream or faith-based.

d) Barriers to accessing support

Q13. "In your view, generally speaking, what are the biggest barriers to accessing mental health support?" This could be informed by your personal experiences, those around you, and your community knowledge. Pick up to three, based on which are most relevant to your experience and or your knowledge

n=634



This section covers the overarching barriers that prevented people from accessing mental health support in general, whether that was faith-based counselling or mainstream support.

These included:

- Social and cultural level barriers: stemming from negative societal and cultural attitudes towards mental health, as well as stigma from one's support network (e.g. friends and family);
- Individual level barriers: these refer to each person's attitudes, behaviours, and understanding of mental health.

We further identified structural barriers, which refer to gaps and shortfalls in the structures of mental health support provision. Examples include distrust in the healthcare system, insensitivity from staff, or experiences of racism or classism. These are explained further in section e), which discusses mainstream counselling.

i) Social and cultural barriers

From our survey, **35%** of respondents (n=634) said that one of the biggest barriers to accessing mental health support was the fear of being judged.

35% also cited 'concerns about what other people might think' as a major barrier.

"Muslims in my community find it really hard to accept that they have depression. They consider it a sign of lack of faith."

"Mental health support or counselling is belittled in certain communities, because they expect you to put on a brave face and get on with it. To them, it shows weakness or is considered excessive and unnecessary."

As a result of stigma and a cultural lack of awareness and acknowledgement of mental health, respondents felt they had no one to turn to when they were experiencing mental health problems. **55%** of respondents (n=666) said that they had not been supported by a family member with their mental health:

"I am afraid of my parents' response...my mother has made an effort to learn more about mental health, although I still fear she wouldn't understand the reasons I'd like to try therapy."

A small number of participants also expressed the presence of unhelpful cultural beliefs promoting misconceptions and misunderstandings of mental health.

"Usually my family does not want anyone to know about mental health problems and put blame on the evil eye, possession of jinn[2] or magic."

ii) Individual barriers

38% of survey respondents (n=634) said that a major barrier for them in accessing mental health support was not knowing where to go.

Although only a small percentage **6%** said that they are unsure that mental health exists, this still represents a significant number of people who would benefit from a greater understanding of mental health.

Beyond that, many respondents also made comments such as "I don't feel like my problems are serious enough" or "my issues aren't serious enough compared to others".

"I don't feel like I hit the threshold level to access counselling, like my issues aren't serious enough compared to others."

"You sometimes think that your problem is not important or too small to access the services."

Analysis

Social, cultural, and individual barriers often relate to stigma. These can lead to feelings of inferiority, guilt, or inadequacy which can further exacerbate mental health challenges. Such feelings can also translate into internalised stigma [17], for example thinking that seeking help is a sign of weakness, or playing down symptoms to avoid being labelled.

These barriers reflect the need for more discussion and understanding of what mental health is within the Muslim community, as well as addressing where stigmatised narratives come from, what purpose they serve and where and how to dismantle unhelpful ideas that could lead to worsening mental health.

Naturally there are strong defences that take hold (minimisation as defence and or avoidance mechanisms) which can be seen to be reflective of the wider community stigma attached to mental health. This is in stark contrast to the normalisation of mental health across a spectrum for all individuals which was present in Muslim communities historically and understood as part of the whole self. The need for increased education and awareness in order to normalise mental health is evident. The provision of easily accessible and culturally tailored services to reflect this would help to alleviate some of the barriers and further the impact of some of the initiatives which have already made significant contributions in this area. Furthermore, embedding these within community structures such as Mosques and Islamic centres would present an opportunity for a tangible shift in attitudes more generally. Ensuring professional standards within such provision however would be an essential prerequisite.

2. Within Islamic theology, there are two positions on this, one being that *jinn* are from a spiritual realm that have little to do with human life. The second position holds that *jinn* are spirits that may appear in the form of a human or an animal. There is contention relating to whether they can take control of a person and in this regard cultural narratives are often superimposed over theological understanding.

e) Mainstream counselling

i) Barriers to access

Some participants were concerned about confidentiality issues linked to a distrust of public services. Respondents were worried that employers would find out about mental health issues through their GP, and the long-term repercussions of having mental health issues stated on their record.

Respondents felt that they wanted faith to inform their counselling (n=332) . **84%** of respondents said that Islam is a big part of their identity and they would like it to inform the counselling they receive. **44%** felt that faith-related issues weren't dealt with through mainstream counselling.

''I've only started my counselling and so I'm not sure how beneficial it will be just yet. The counsellor is non-Muslim and there are some cultural barriers though she tries to be nice.''

''It made me realise I need faith-based counselling. As much as my counsellor tried to be understanding, having to explain certain cultural matters just made the sessions less than effective.''

1 in 5 people felt judged or dismissed as a Muslim by structured, formal counselling. However, respondents overall felt mainstream counselling did help in some capacity.

- There was a general sentiment that practitioners within mainstream settings have more formal training and qualifications than those in faith-based settings.

- Waiting lists: **53%** of respondents said that waiting times for NHS care were too long and they did not have the financial means to pay for private support.

ii) Enablers

Widespread availability: The majority of respondents accessed mental health support through mainstream routes - either NHS or private because of its widespread availability.

Some respondents were concerned about confidentiality issues with employers and the repercussions of having a history of mental health issues stated on their medical records. Equally, they felt reassured that their mental health issues would be safely guarded from their communities and families.

Analysis

It was evident that there was a desire for service provision that catered to specific nuanced whole person needs that were faith centred. On the one hand, there was confidence in the professionalism of mainstream services, by some, particularly so in relation to patient confidentiality (though this trust was not there for all and is discussed in further detail below). For those that experienced or perceived professionalism in these services, it facilitated the opportunity for increased mental health disclosures. Simultaneously, there was distrust of public services more widely linked back to structural issues around identity and stigmatisation at a macro level. NHS and private practice were being accessed more readily due to their widespread availability as opposed to their effectiveness or their trustworthiness to the Muslim individual seeking support. The impact of the Prevent framework on accessing mental health services needs to be accounted for here. Increased concerns of the securitisation of healthcare, particularly relating to primary care staff being legally obliged to flag individuals they may percieve as concerning, have been raised by MEDACT and Younis et al. [18] amongst others. For individuals who are already vulnerable, unable to trust public services, yet wanting and needing to seek support, this leaves few options and would cause further alienation and worry and perhaps a worsening of mental strain. There were concerns over confidentiality in disclosing mental health struggles particularly whether these may be shared with employers and other services or individuals and the negative impact they could have.

NHS or private services were not always the most effective, with a lack of cultural insight and understanding being highlighted as problematic areas. The consequences were individuals needing to explain their context (religion: Islam, culture) and nuances before being able to explain, explore and process their mental health concerns, and even then there was no guarantee they would be fully understood or appropriately responded to. It is concerning that patients would need to offer 'education' before they could be understood, creating a significant barrier for those who are potentially feeling overwhelmed, distraught and are seeking help. This dynamic presented an accessibility barrier despite being an 'accessible' and known institutionalised service, and left individuals feeling dismissed. The long waiting times to access these services create additional barriers. Such experiences can further exacerbate mental health concerns and isolation already experienced resulting in missed opportunities for earlier interventions.

There was a tangible demand for faith-based counselling among respondents, with many recognising that they needed faith-based counselling after having tried mainstream routes. This highlighted the inadequacy of current service provision to effectively cater to the faith and culturally sensitive needs within therapeutic settings for the Muslim community. Furthermore there was an absolute need for professionalism and confidentiality within any service provision. The indication towards accessing safe spaces for mental health disclosures related to both safety within own communities and safety at the macro level. Such concerns therefore must be accounted for in order for service provision to increase accessibility.

f) Faith-based counselling

Faith-based counselling is counselling or therapy that involves a spiritual and or religious approach. It broadly adopts a more holistic approach to understanding an individual's emotional, spiritual, and psychological wellbeing within a religious and spiritual framework. This can further include the integration of secular-based psychological theories and interventions or techniques. The sessions are delivered by a professional who shares, or has a good understanding of the client's faith and spirituality and cultural frames of reference.

i) Barriers to access

Lack of availability: Some participants expressed that they had difficulty finding a faith-based practitioner, and that there is not enough faith-sensitive or relevant mental health resources, such as reading materials or workshops. This was also evidenced by the fact that for survey respondents who had not previously accessed counselling, the most popular option in accessing counselling was through free, faith-based practitioners.

"I've had to access faith-based counselling online from someone abroad because no one is available here."

Concerns around professionalism: Several respondents mentioned the lack of knowledge and inadequate training amongst practitioners as a concern for faith-based counselling. They expressed concerns about confidentiality and judgement from the counsellor.

A small number of survey respondents were open to faith-based counselling, but only if they were confident that the practitioner did not hold unhelpful, orthodox views towards mental health and that they took a person-centred approach.

Lack of holistic approaches: There were concerns by some respondents that faith-based counselling may be too narrow in focus - only addressing the faith aspect of mental health but not its medical and psychological aspects.

"More often than not, mental health in our Muslim community is always targeted from an Islamic perspective in totality without considering that mental ill health is something medical and psychological, which also requires isolated support. Having the two overlap without directly dealing with the core issue makes things harder."

Judgement: The experience of judgement was another recurring theme amongst respondents - there was a tendency to blame mental illness on one's faith.

"My experience with faith leaders as mental health advisors is that they would be judgmental or push their ideas onto you."

"I don't like when my depression and anxiety are blamed on lack of prayer, etc"

"If you live in a small community, as women there are trust issues about how confidential the counselling would be and does it come from a place of judgement? Not all religious leaders have taken on the issue of mental health in a measured, sensitive and understanding fashion. Also there is not always a qualified faith-based counsellor in smaller communities."

"I also find many faith individuals judgemental and too quick to provide 'facile' solutions to major mental health issues. Telling people with severe anxiety disorders or depression that they need to "put their faith in Allah" or "have more faith" is not particularly helpful."

Poor quality services: An example of a poor quality service was highlighted by a respondent who felt the service they accessed had not integrated faith more holistically and lacked depth. Another respondent highlighted the issue of Islamic counselling feeling like a profit-making industry that was lacking in meaning of what it meant to be a Islamic counselling service.

"I had poor support from [a well known Islamic counselling service]…. I wanted a support service that incorporated my faith into my worldview. The counsellor… was cold (although her words were very supportive in a mainstream way) and the only 'religious' aspect was that she advised I watch YouTube videos of certain duas…. It totally lacked the depth I expected…. I ultimately went through my GP who referred me to mainstream NHS-funded counselling, and even though it lacked depth, I felt their intentions and world view was at least honest and transparent.''

"Just based on my experience. I think there is a GREAT need for it, but I don't think our community has a holistic approach enough for this. I felt with the fee paying 'islamic' counselling service I initially approached, that it was purely money-making - like they'd tapped into a market but not thought through what it meant to be an islamic counselling service."

Lack of inclusivity: There was a sense that faith-based counselling was not inclusive, with a one-size-fits-all approach and thereby alienating certain groups.

"Our Islamic Centre does not understand any hidden disabilities, including mental health. There is no support from the management and members only judge- not help."

"I would prefer a female counsellor and often Islamic counsellors are male."

ii) Enablers

When faith-based counselling worked for people, they reported it as being really effective, especially when adopted alongside clinical treatments.

Positive experiences: Survey respondents were asked whether they would recommend faith-based counselling to others, and to elaborate on their reasons. The majority **69%** (n=712) said they would recommend it, while 5% said they would not.

Cultural sensitivity: For those that recommended faith-based counselling, many commented that the integration of Islamic culture helped them feel better understood, and therefore increased trust in the process. Others also felt that faith was an important aspect of their lives, which meant that spiritual healing supported other aspects of their health and wellbeing, including mental health. For many, as Islam was woven with their sense of self, the healing and recovery process needed to be embedded within an Islamic theoretical conceptualisation of psychology.

"I would recommend it because having a therapist who is a Muslim, means that you are working with someone who has a similar framework and base understanding as yourself. Spiritual practices are better understood and the framework of Deen is valued."

"I felt that my spirituality wasn't taken into account enough when I had non-faith-based counselling. Also felt that the counsellor just didn't get my frame of reference."

"I am a practising Muslim and my faith should inform all aspects of my life including counselling. Often those who do not understand my faith, heritage and cultural norms are unable to provide adequate support, and miss vital information which should be centred in a treatment plan."

Integration of spirituality and mental health perspectives were seen as more holistic sustainable solutions:

"Islam is a part of my identity and a lot of my thoughts and feelings will be intertwined with my beliefs. Having a faith-based intervention is key to getting to the root of the problem and getting sustainable solutions."

"Faith based counselling is more nuanced and I believe it has the ability to more specifically cater to a person's needs, more so than regular, general counselling."

"Faith-based counselling would be more relevant and constructive for me. It would potentially provide appropriate solutions and give me culturally and religiously sound ways to move forward."

Faith-based counselling can also act as a bridge to get people into mainstream/ clinical support:

"My main concern was distrust of the treatments. Being supported and faith-based gives me more courage to try."

Another respondent shared that ***"It helps alongside clinical treatment."***

Analysis

Strong preference for faith based services was apparent. Respondents felt this would take into account the core of their identity and therefore support them in a more holistic manner which they could connect with. This was felt to be significant in terms of personal identity as well as in relation to mental health needs. Without access to faith based approaches individuals were left feeling unheard and misunderstood, with mental health needs remaining unaddressed. Therefore, recommending faith based provision was also strongly endorsed. For some cases, faith based provision also facilitated access to mainstream services, having first established and developed trust within the faith based support. This indicated the potential for collaborative approaches.

Parallel to this was the need for adequate levels of training and professionalism within faith based provision. It was clear that many were utilising informal forms of support alongside counsellors, often from Imams who did not hold prerequisite counselling and or mental health training or experience. Therefore professional understanding and experience of mental health concerns and holistic approaches were often absent. As a result some Imams mistakenly conflated mental health concerns with individual levels of faith practice, instead of having a clear understanding of the distinction between the two. This resulted in further alienation. In cases where counselling was accessed, not being able to access the preferred gender counsellor presented further barriers for some.

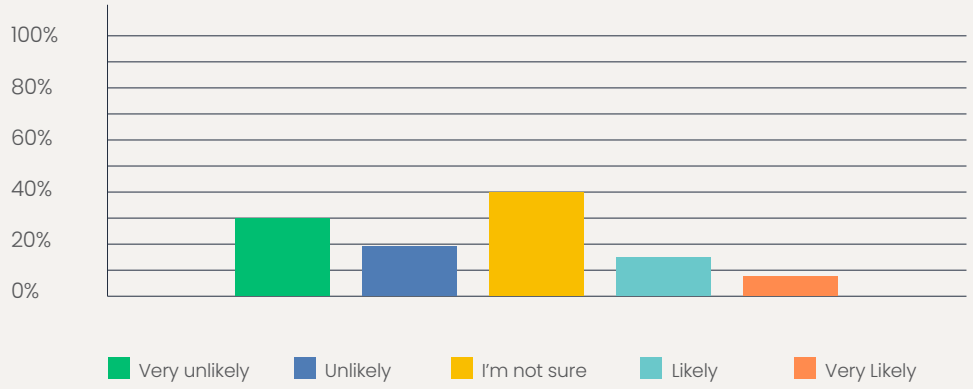
The consensus indicated that there was a strong need for the development of faith based provision as a whole, both within communities and more widely across the mental health sector. While there was a high demand and potential to cater to specific needs within the Muslim community there is equally a requirement for the presence of professional standards. Furthermore, awareness of resources already present within communities was clearly inadequate. Such services require increased exposure across numerous platforms.

Current platforms include the Muslim Counsellors and Psychotherapists Network (MCAPN) and the Islamic Psychology Professional Association (IPPA) as examples. Whilst there have been many initiatives aimed at training imams and community leaders within mental health care, this requires more structured, ongoing collaborative approaches in order to ensure continued development.

Equally, it is apparent that the current level of faith informed service provision lacks capacity to meet the extent of the demand.

g) Mental health support from mosques & Islamic centres

Q18. "How likely are you to approach a mosque/Islamic centre to recieve support with your mental health in the future?"



The majority of survey respondents (**90%**, n=665) had not previously been supported by a mosque or Islamic centre for their mental health. The number of participants who had received support from a mosque or Islamic centre translated to 47 participants (7%). The remaining 3% preferred not to say.

Only **21%** of respondents (n=655) said they were likely or very likely to approach a mosque or Islamic Centre to receive mental health support in the future.

i) Barriers

Confidentiality issues: some respondents had negative experiences in the past, where their personal information was shared with others after confiding in a faith leader.

Concerns around judgment: 25% (n=558) of respondents said that they had not received support from a mosque or Islamic centre as they were worried about being judged.

"Support provided was wholly inadequate and implied that the issues are due to not being a strong Muslim."

Lack of availability and awareness: 48% (n=558) of respondents said that they did not reach out to a mosque or an Islamic centre for support because they did not offer mental health support or did not have the resources.

"My local mosque has never even spoken about mental health, if I approached them about something like this, they would not be able to support me."

"I feel there is a very long way to go in this topic! Most mosques don't seem well set up or have trained people who can offer good support. So needed but many don't trust that they will be dealt with confidentially either."

Respondents also said they were not aware of mental health support services even when they were being offered.

There was a view among a few respondents that mental health was not the responsibility of mosques or within their remit.

Lack of knowledge and invalidation of mental health: Some people had concerns about the quality of mental health support from mosques and Islamic centres, including worries that it would spread misinformation, that staff lacked appropriate training, and that they would be subject to stigmatisation.

There were concerns that the advice on offer would not engage properly with mental health discourse, and instead suggest that their situation would improve by being a 'good' Muslim.

"I didn't know that they have mental health support. Also, I fear that they are too cultural and just advised to pray, fast, do charity, be patient!"

Inclusivity: Additionally, several people mentioned that their local mosques were not accessible to women, or that in their culture women do not go to mosques.

" Women in our country don't really go to mosques, we pray from home."

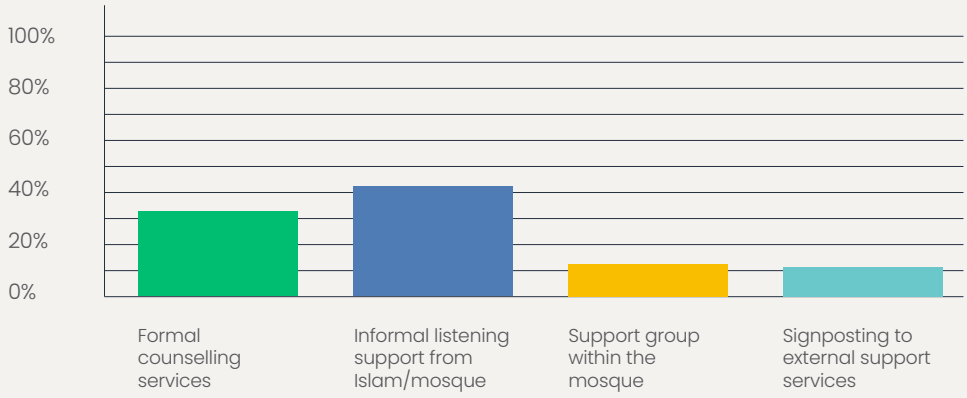
"Most mosques around my area don't allow access to women."

Some women also expressed that mosques and faith-leaders were male-dominated, which acted as another barrier.

"I think the leadership in mosques should be more visible and approachable to the general public. Another barrier is the lack of female presence in leadership roles."

Q16. How were you supported by the Mosque/Islamic Centre?

n=45



ii) Enablers

Only 7% (n=45) had accessed support from a mosque or Islamic centre. In this regard we have limited data, however we can share the following responses:

Respondents mostly benefited from informal listening support services:

"Just that someone was there who understood my husband and appreciated what was going on in his life and was really kind and accommodating."

Spirituality classes: indirect activities such as spirituality classes have helped some people address mental health issues without being explicit mental health support.

Analysis

Mosques and Islamic Centres were not the primary sources of support for mental health concerns within the Muslim community. There was a general feeling that mental health was not within the remit of Mosques and Islamic centres, and some respondents raised concerns about the ability of mosques and Islamic centres to meet these needs.

For those who had not received support from a Mosque or Islamic centre, 36% said it was because they had not needed to reach out for support, therefore the lack of participation does not necessarily reflect low quality service from mosques. Having said this, people who had reached out to mosques for mental health support were on the most part not complimentary about the support they received. Mosques are generally not equipped to deal with mental health and have a history in the UK of being spaces mostly for male worship and some Islamic studies classes. The vast majority of those surveyed preferred faith-based counselling support, yet equally did not turn to the Mosque for this. Whether or not such an uptake would be influenced by increased service provision cannot be determined at this stage as the majority of Mosques do not provide such services.

The need to reimagine our spaces and to determine which spaces feel safe to access mental health support was alluded to. Mosques in general are not centres for providing therapeutic support. However the idea and ideal of a mosque for many holds the concept of a supportive, nurturing, healing, connecting environment and community, emulating the way of the Prophet Muhammad (peace be upon him) and his teachings derived from the Quran and through his Sunnah (way of living and being). When this is missing and there is a need for it, it can feel painful for those requiring that support which can then lead to a sense of being let down or abandoned. This reimagining of spaces needs to also include rethinking therapeutic support and counseling rooted in indigenous Muslim perspectives. The idea of 'Cultural Safety', *"is an antiracist, decolonising and educational innovation originating in New Zealand, which emerged as "a way of overturning individual and structural racism experienced by colonised Māori peoples in New Zealand"*. It has gained traction in Australia and is being discussed in a UK context in some circles (Lokugamage et al., 2021 [19]). There is a need to discuss the potential of translating 'Cultural Safety' (CS) into the UK to reduce racism within healthcare and for 'CS' to become more widely embedded. Ideas from this concept can be drawn upon for centering Muslim Mental healthcare provision.

Mosques can work collaboratively with practitioners and researchers in the community to start creating these spaces. Consideration needs to be given to whether such therapeutic spaces should be housed within a Mosque or whether the fear of judgemental attitudes may already present a barrier. Equally clinically cold medical environments are also not inviting.

There is a need for spaces that do not feel punitive or judgmental - this needs to be rethought and reworked. Addressing this could also include educating the community regularly, offering reminders on the etiquette of dealing with and relating to people who present with distress or what we consider mental ill health, rooted as mentioned in the Prophetic way of gentleness and kindness, offering compassion and support. Furthermore, applying teachings of not talking about people, holding their *amanah* (trust) could develop an improved offer of confidentiality. These are dilemmas for professionals and the community to work through in general - re-imagining and creating spaces that feel warm, containing, safe, kind, supportive, nurturing and healing. We need to rethink the inner (as well as outer) architecture; not just the physical but how we engage in and what these spaces mean to us in terms of our psycho-spirituality and emotions. Environmental psychology has a role to play here too; how inviting spaces are for people with diverse needs, sensory issues, anxiety, women, people from different ethnic groups.

8. Conclusion

The findings of this report demonstrated how mental health was regarded just as important as physical health. However, accessing support for mental health struggles was not always a linear process.

A lack of knowledge and understanding regarding mental health concerns, coupled with cultural normative approaches, presented barriers. Such barriers not only impacted help seeking behaviours, but furthermore how mental health concerns themselves were understood and interpreted. Consideration of additional barriers for minorities within minorities, at the intersection of lack of awareness and understanding, was further highlighted. The nuances involved in the various levels of considerations therefore came to the forefront. In line with precedents, both negative and positive outcomes related to Covid-19 and lockdowns were evident.

Counselling services were utilised by 48% of the sample (n=744). This demonstrated counselling as being a viable intervention, with services more readily accessible (NHS) being utilised over other service provisions. Private fee-paying services however also demonstrated a high uptake. This indicated the drive towards seeking support, despite fears around negative social stigma presenting as a significant barrier to accessing support.

Despite this uptake, the lack of adequate service provision was highlighted strongly throughout the data. Respondents expressed how mainstream services often let them down and did not cater appropriately to their needs. Simultaneously, the presence of trust in mainstream services, particularly in relation to confidentiality away from community members, was expressed. A desire to have faith based needs addressed within service provision was apparent.

Faith-based provision was presented as holding holistic and more meaningful opportunities for healing. By catering to lived identities it allowed respondents to express their needs and have those needs met. It further served as a bridge to accessing mainstream or clinical support in some cases. Concerns however were raised in regard to how holistic some faith services actually were and whether all mental health concerns would be negatively transposed onto individual levels of faith. Concerns regarding confidentiality and trust were also raised. Therefore, whilst the provision of faith based services was advocated, equally ensuring it met professional standards and Islamic ethics and etiquette were deemed essential. Questions therefore arose in respect to whether such provision was required to be based within faith institutions themselves or whether the level and appropriateness of such provision took precedence over where such provisions were located. In extension to this, concerns surrounding levels of professionalism both in training and conduct, and holistic approaches towards understanding mental health, were echoed in relation to provision within Mosques and Islamic centres.

The presence of informal support networks within such institutions however were raised as being central to accessing external services, whether through signposting or social support mechanisms. Unstructured forms of social support were highlighted as strengths within faith-based institutions. This served as a reflection of the potential for utilising strength based community approaches, which could be further harnessed through collaborative approaches with external organisations. This particularly applied where concerns were raised in relation to professional conduct and confidentiality by individuals who meant well, but did not possess the right training and experience to work within professional theraputic parameters. Taking collaborative approaches would increase understanding, development and the mutual sharing of good practice. Such approaches further serve to avoid the one size fits all approach.

In conclusion, there was an openness to seeking support for mental health concerns, despite the existence of barriers relating to social stigma and a lack of holistic service provision. Lack of professionalism was raised with regards to faith institutes and those providing faith based mental health provision. Finally and most significantly, there were real concerns regarding the adequacy of existing mainstream services; what was apparent was the urgent critical need to decolonise mainstream healthcare systems from education through to delivery, the need to centre and value indigenous Muslim perspectives and knowledge on mental health, psychology and healing, and the need to create safe and trauma aware spaces all round. Each area of inquiry presented with their own strengths and weaknesses, indicating the need for collaborative approaches to mental health support and the reimagining of safe spaces available for this.

9. Recommendations

We have developed a series of policy entry points and recommendations aimed at improving access to mental health support for Muslims. These have been informed by the barriers and enablers outlined in the 'Findings' section. Recommendations have been categorised according to type of service, and informal and formal support groups.

For the general community working and volunteering in Muslim mental health

- Signpost to holistic approaches of support through a mixture of faith-based and clinical support - these should be appropriately informed and relevant.
- Raise awareness relating to preventive mechanisms towards better mental health and wellbeing.
- Do not always assume that support from the local mosque is desired. Consult people for their preferences.
- Co-creation of new methods or adoption and utilisation of established methods such as informal support networks, rather than superimposing methods from pre-existing research conducted with other (often non-Muslim) population groups.
- Community based support should facilitate and support therapeutic interventions - this is an area requiring active development. It further requires working in collaboration with informal systems of support.
- Continued need to raise awareness regarding mental health including over life-span development.
- Be trauma-informed.

Community organisations

In addition to recommendations for general community and volunteers:

- Centering indigenous and Islamic ways of knowing, and integrating these with relevant psychological counselling skills; being mindful of engaging with and maintaining a decolonising perspective.
- Actively and openly challenge common misconceptions.
- Provide workshops that inform and educate the community about mental health issues and challenge misinformation.
- Reach those who do not usually have the capacity to access mental health education, by doing targeted outreach work.
- Provide training and information for the community on patient confidentiality laws; include laws pertaining to healthcare systems as well as those pertaining to workplace-funded counselling and others.
- Ensure programmes are inclusive of minorities within minorities. Research each individual community demographic and needs.
- Be trauma informed.

Mosques and Islamic centres

- Faith-based centres need to work on making their spaces feel safe, non-judgmental and impartial. Consider how this could be done both physically by creating designated spaces, and through encouraging cultural shifts in attitudes.
- Be open towards conversations about mental health and integrate mental health issues with programmes and activities at the mosque or Islamic centre.
- Provide workshops that inform and educate the community about mental health issues and challenge misinformation.
- Be trauma-informed.
- Publicise services where they are available.
- Signpost to referral services when there is a lack of capacity in-house. This includes maintaining a resource bank of literature and information leaflets from local and national mental health support services.
- Presence of multi-disciplinary teams available throughout the year.
- Provide mental health first aid training for Imams and teachers leading congregations and working in mosques and supplementary schools.
- Genuinely take action to include women, people of minorities, those with unseen disabilities and experience of mental health, at all levels from boards and trustees to ensuring service provision and needs are met.

Faith-based counselling services

- Be more holistic, integrating spiritual and faith-sensitive approaches with appropriate and relevant evidence-based, clinical techniques.
- Support and (further) train service providers and individual Muslim counsellors and consider their wellbeing.
- Signpost to existing mental health support directories.
- Co-create safe spaces with the community and those likely to use therapeutic support services in future.
- Be trauma-informed.
- Engage in continued professional development.

Mainstream Counselling services

- Reach those who do not have the practical means or know-how to access mental health education, by doing targeted outreach work in a culturally appropriate manner.
- Co-create services utilising resources and expertise already present within Muslim communities.
- Adoption and utilisation of established methods such as informal support networks, rather than superimposing methods from pre-existing research conducted with other (often non-Muslim) population groups.
- Be trauma-informed.
- Engage in regular faith and cultural sensitivity training.
- When working with Muslims be curious about and willing to learn about and centre indigenous and Islamic ways of knowing, and integrating these with relevant psychological counselling skills.
- Establish genuine collaborative relationships of learning with Muslim mental health professionals, therapists and researchers as well as Muslims with experience of mental health services; whilst willing to engage in reparative and trust-building healing work.
- Be mindful of engaging with and maintaining a decolonising perspective, being consciously socially just, and challenging own as well as structural and systemic cognitive bias and negative assumptions at all levels.

Clinical commissioning groups

- Commission research internally to expertise already held within communities (this research needs to start addressing more complex mental health needs of the Muslim community).
- Increase representation of Muslim communities in IAPT services and creation of adjunct services to improve the quality of services for Muslim patients.
- Create funding schemes and mentorship programmes within the NHS that genuinely work together in co-creating training and service provision with Muslim experts in the field.
- Create long term sustainable funding streams for community groups working in Muslim mental health; incorporate an autonomous model where individuals and grassroots organisations have a voice in the decision-making processes in relation to service design and delivery.
- Consider alternative career entry routes, whilst maintaining standards, as an alternative to existing roles governed by established accreditation bodies which hold problematic structural and systemic alienation and racism concerns.
- Consider the impact of trauma in service design.

10. About the authors

The Lantern Initiative CIC

The Lantern Initiative is a Muslim-run grassroots social enterprise based in Peterborough. Their objectives are to educate and raise awareness of mental health issues in the Muslim community, to help break down the associated stigma, and to empower communities in seeking and accessing relevant support with their mental health and wellbeing.

Safura Houghton contributed to the survey design and supported the co-authoring of this report. Hana Sayeed contributed to the survey design and supported the finalisation of this report.

Civil Society Consulting CIC

Civil Society Consulting is a not-for-profit organisation, which mentors grassroots groups into strong, resilient and effective organisations, thanks to expertise in fundraising, organisational capacity building and development, communications, social and community research, and evidence-based policymaking.

Francesca Godfrey and Yasmin Jiang designed the research and contributed to this report.

Aaliyah Shaikh

Aaliyah graduated from University of Cambridge with an MEd in Psychotherapeutic Counselling and is a certified clinical trauma therapist. Currently completing PhD research in Health Psychology at City, University of London, her thesis has explored British Muslims' experiences of the perinatal period. Aaliyah founded Rahmah Wellbeing in 2012 as a counselling and psycho-education service based in an Islamically rooted understanding of psychology. She is a Mental Health researcher whose interests include: Muslims' experiences of mental distress, Islamically rooted psychology, decolonial research, critical psychology and medical humanities, foetal psychology, intergenerational trauma, attachment disorders, adverse childhood experiences, and how early experiences from the time in the womb and prior impact life development and health outcomes compounded by various intersections. She was previously a Muslim chaplain for the NHS and holds a MA in Muslim Community Studies, a postgraduate diploma in Social Studies and a Higher Education Certificate in Psychodynamic Counselling Skills. Aaliyah has recently authored a chapter for the upcoming book on "British Muslims, Ethnicity and Health Inequalities":

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Rahmanara is a Lecturer and Course Lead in Islam and Pastoral Care at the Markfield Institute of Higher Education (MIHE). She has a BSc in Ergonomics from Loughborough University, MSc in Psychology from Nottingham Trent University, and completed her PhD at Brunel University London (ESRC funded). Her PhD research focused on understanding domestic violence and abuse within UK Muslim communities. Her additional research interests include forensic mental health, child sexual abuse, spiritual abuse, Islamic psychology and the impact of intersectionality within all of these. Rahmanara has authored two books in relation to domestic violence and abuse, published by Ta-Ha Publishers, and is currently working on various other scholarly outputs. Rahmanara actively engages with domestic violence and abuse training and mental health and wellbeing awareness at a grassroots level. She is also the Head of the newly formed MIHE Centre for the Study of Wellbeing.

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