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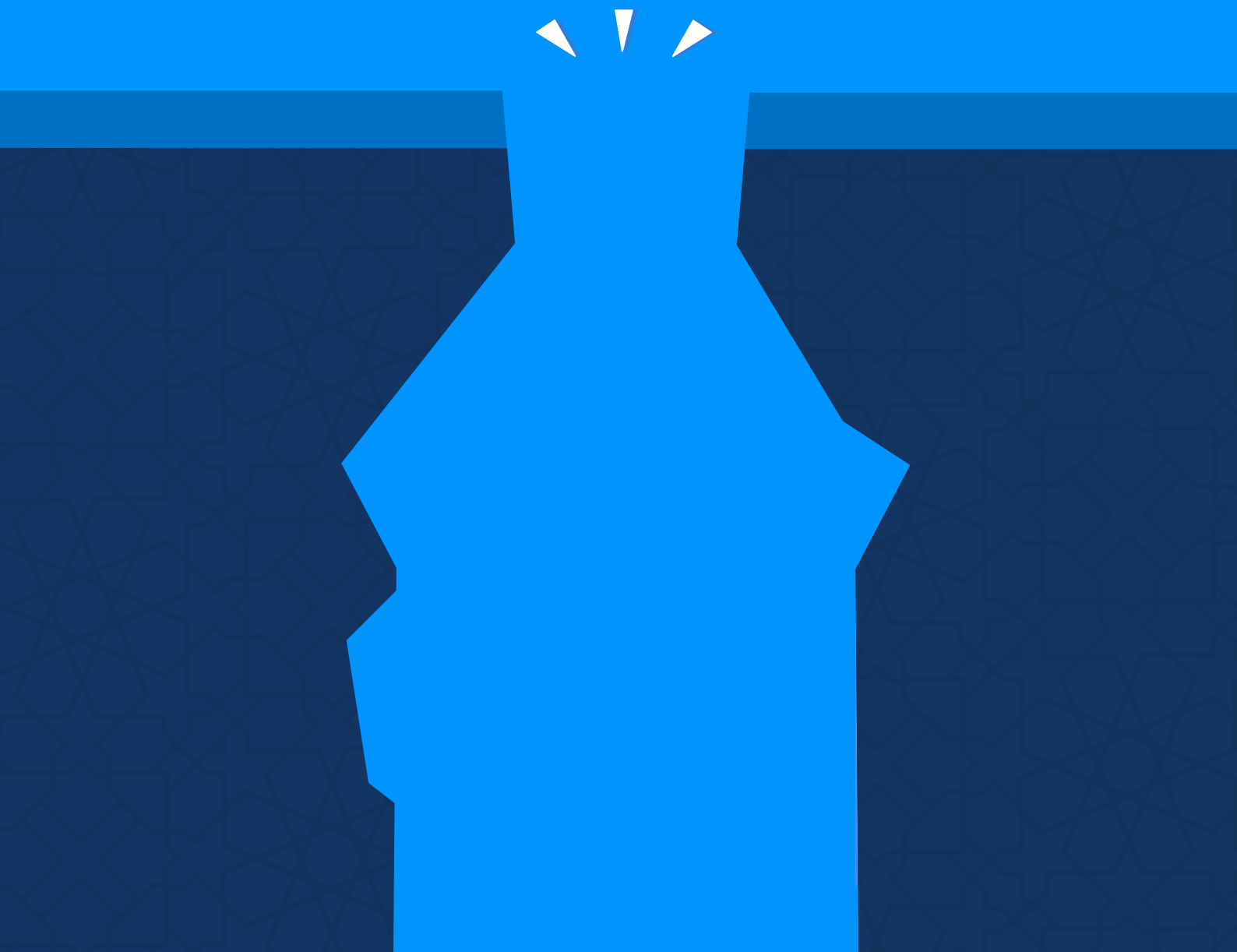
RESEARCH REPORT

Barriers to Seeking Mental Health Support

in the Muslim Community



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Barriers to seeking mental health support in the Muslim community & can Inspirited Minds workshops reduce these barriers?

Contents

Introduction

The Muslim population in the United Kingdom is 5.3%, making it the second largest religion in the country (Office for National Statistics, 2018). However, Muslims are still widely underrepresented within mental health statistics. Close to half of the UK population has considered themselves to have suffered from a diagnosable mental health disorder at one point in their lives (Mental Health Foundation, 2016). The most prevalent of these disorders include depression and anxiety, with 1 in 6 individuals reporting suffering from symptoms of these mental disorders. Statistics have also revealed that 1 in 8 individuals are receiving treatment for mental health conditions (Baker, 2020). Regardless of these numbers, previous literature has reported that many Muslims experiencing mental health issues would prefer to go to a family member as opposed to seeking out formal treatment (Aloud & Rathur, 2009). In another study consisting of 459 participants, approximately 16% of the participants stated wanting to seek help through counselling. However, only 11% went through with receiving counselling sessions (Khan, 2006). This displays the lack of treatment in Muslim communities and displays important issues regarding mental health stigma which will be discussed further in this report.

Important issues in the Muslim community regarding mental health include stigmatization, misconceptions of mental health and difficulties in communicating with mental health service providers (Ahmad et al., 2016; Al-Adawi et al., 2002; Aloud & Rathur, 2009; Ciftci et al., 2012; Khalifa et al., 2011). In a review looking at the mental health issues present in Muslim Americans, it was reported that many Muslims faced the following barriers when trying to access support for mental health (Basit & Hamid, 2010):

(a) misconceptions of mental illnesses and not knowing the prevalence of these illnesses in Muslim communities
(b) language barriers
(c) preferences to seek help from traditional healers
(d) stigma and family honour
(e) unexposed to the concept of counselling and psychotherapy.

Several studies have shown the perceived and existing barriers ethnic minorities may face when seeking out support from mental health services in the UK and include: disinclination in accessing mental health services due to discrimination, the stigma surrounding mental health, language barriers and the lack of culturally-specific services available (Ali et al., 2017; Jason, 2018; Memon et al., 2016; Pilkington et al., 2012; Salaheddin & Mason, 2016). Although the findings of these studies have highlighted the factors that may be blocking individuals of ethnic minorities from making use of mental health services, perceived barriers specifically faced by Muslims in the UK have not been previously identified.

It appears that the relationship between service users and mental health professionals influence whether individuals seek support from mental health services. This has been attributed to a lack of cultural understanding, including suspicion and mistrust of therapies. Under this theme, Memon et al. (2016) established further barriers, including inadequate communication between those seeking help and mental health providers, discrimination and power and authority imbalance between service users and professionals.

This means that mental health services need to address the mistrust of mental health services within the Muslim community (Amri & Bemak, 2013), including looking to recruit those from minority groups (Ragavan, 2018) to break the barrier of representation and diversify the face of services.

Religious leaders have been found to play a prominent role in maintaining the mental health of their community members (Ghorbani et al., 2000; Leavey, 2008). Therefore, mosques and imams may provide mental health support and spiritual guidance to those within the Muslim community. For example, in a cross-sectional study by Abu-Ras, Gheith and Cournos (2008) it surveyed 22 imams to see the role they play in the promotion of mental health. The results showed that despite no formal mental health training many worshippers turned to imams for support. Therefore, individuals may seek mental health support from alternative support mechanism that already exist in the community that are percieved more fitting with their religious beliefs.

Given the evidence that Muslims are less likely to seek out mental health support, this study aims to discover the perceived barriers Muslims face when accessing mental health services. It is expected that similar barriers will be identified, as those that were reported by Basit and Hamid (2010). Identifying these factors can lead to improvements in the mental health services available, especially for Muslim recipients, and gain an understanding as to why there are inequalities in statistics regarding Muslim's and treatment for mental health.

Methodology

Participants

Data for this project was collected over a period of 4 weeks. People attending the Inspirited Minds (IM) 'Muslim Minds: COVID19' webinars were invited to take part in a study looking at the barriers faced by Muslims while accessing mental health services and the effects of IM webinars on these barriers. Individuals were emailed and verbally reminded to complete pre and post-webinar questionnaires before and after the webinar, respectively. While completing the post-webinar questionnaire, participants were given the option to volunteer for an interview to look at barriers faced by Muslims in relation to mental health in detail. Demographic details of the total number of respondents and analysed respondents are presented in Table A.

Materials & Procedure

Invitations for the Muslim Minds: COVID19 webinars were advertised on Eventbrite with a description of the content that would be presented in each webinar. These events were also promoted on the IM website and other social media platforms (e.g. Instagram and Twitter).

IM webinar sessions took place over a period of 4 weeks during the month of Ramadan 2020. Due to the first lockdown in the United Kingdom and Muslims practicing Ramadan from home, IM arranged for speakers to talk about mental health via online webinars. Each webinar lasted for an hour and a half covering a variety of topics that incorporated Islam within mental health.

The first Muslim Minds: COVID19 webinar (Heartfulness and Mindfulness: Like the Prophet Muhammad (SAW)) was presented by Saeed Nasser. This first webinar aimed to teach viewers about the concept of heartfulness; how mindfulness was embedded within the Prophet's (SAW) routine, and how Sunnah can be utilised to reflect on current events (e.g. COVID-19). The following week, Khaleel Kassim presented a webinar on Emotional Intelligence and how Muslims can emulate the Emotional Intelligence of The Prophet (SAW). Kassim also covered the importance of choosing positivity when faced with difficult times. In the third Muslim Minds webinar, Wajid Houque and Fathima Hameed reflected on their journeys with mental health and how creative coping methods have played a role in this journey. For the final webinar, Sheikh Jamal Mohammed described the relationship between the Quran and mental health, and how to apply this to current events; for example, ayaats (Quranic verses) were presented specifically in relation to the benefit of mental health and wellbeing. Sheikh Jamal Mohammed also went over how a Quranic lifestyle can be implemented during and after Ramadan.

Part one of this study required participants to complete two customised questionnaires regarding the IM webinars and their awareness of mental health.

The first, pre-webinar, questionnaire was e-mailed to participants before each IM webinar. In this bespoke questionnaire, participants were initially asked to provide demographic information (Gender, Age group and Ethnicity) followed by asking for details regarding what they hope to learn from the webinars, how many webinars they have attended and how they heard about the webinar in the form of multiple-choice questions and text box responses. Part two of this pre-webinar questionnaire consists of a 6-item questionnaire measuring the participant's understanding of mental health and mental health in Islam. Each item needed to be scored ranging from 1 (Strongly disagree) to 10 (Strongly agree). An example of an item is "I have a good understanding of mental health" and "mental health issues should be given more time in mosques".

The second questionnaire (post-webinar questionnaire) was e-mailed to participants after the end of each webinar. In this questionnaire, participants were first asked to give in their e-mails so responses can be matched to those given on the pre-webinar questionnaire. Participants were then asked which webinar they were attending, and if they had filled in a post-webinar questionnaire before; if this was the case, participants were taken straight to the 6-item questionnaire, that made up part one of this survey. For those who had not filled in a post-webinar questionnaire before, they were asked about demographic information (Gender, Age group and Ethnicity) and how they had heard about the Muslims Minds: Covid19 webinars. Upon completion, all participants had to fill in the 6-item questionnaire that measured their understanding of mental health and opinions on mental health issues being discussed in mosques. For the second part of the survey, participants were asked general questions about the webinars to collect feedback on what had gone well with the four webinars and what can be improved with future events. In this second part, participants were also encouraged to give their input as to which topics should be discussed in future webinars (e.g. postnatal depression, anger issues, suicidal issues and so on). Also, it is in this final part of the survey where participants were given the opportunity to be contacted further for an interview, where they could go into detail of their experiences with these Muslim Minds: Covid19 webinars, and what barriers Muslims face when trying to access mental health services.

Results

Table A - *Demographics of participants completing pre and post-webinar questionnaires*

Variable	Pre-Webinar Questionnaire	Post-Webinar Questionnaire
n	86(%)	75 (%)
Gender		
Female	64 (74.4)	15 (20.0)
Male	17 (19.8)	3 (4.0)
Age		
Under 17	6 (7.0)	-
18 - 22	17 (19.8)	2 (2.7)
23 - 27	20 (23.3)	8 (10.7)
28 - 32	9 (10.5)	2 (2.7)
33 - 40	8 (9.3)	2 (2.7)
41 - 50	17 (19.8)	4 (5.3)
50 and above	4 (4.7)	-
Ethnic Group		
White - British	1 (1.2)	-
Any other White background	2 (3.5)	-
Asian/ Asian British - Indian	13 (15.1)	3 (4.0)
Asian/ Asian British - Pakistani	26 (30.2)	5 (6.7)
Asian/ Asian British - Bangladeshi	10 (11.6)	-
Any other Asian background	2 (2.3)	2 (2.7)
Black/ Black British African	7 (8.1)	2 (2.7)
Any other Black background	2 (2.3)	-
Any other mixed background		2 (2.7)
Other ethnic groups - Arab	12 (14.0)	3 (4.0)
Any other ethnic group	3 (3.5)	1 (1.3)
Prefer not to say	7 (8.1)	-

Pre and Post webinar questionnaires

The pre-webinar and post-webinar questionnaire responses were evaluated using repeated-measures t-test to examine whether IM webinars influence how people perceive their understanding of mental health, and barriers they may face when trying to access mental health support. The results revealed a significant difference in individual's understanding of mental health and support services pre (M= 40.39, SD= 5.79) and post (M= 42.71, SD= 4.27) webinars, $t(27) = -3.27$, $p < 0.005$. The Muslim Minds: Covid19 webinars were identified to being effective in informing the public of ways in which people access mental health and gain a better understanding of mental health, with the incorporation of Islam.

Thematic analysis

The qualitative data from the nine interviews conducted were analysed using Thematic Analysis with a deductive approach being utilised to identify the coding categories (Braun & Clarke, 2006). The qualitative data looked at the impact of the webinar, accessing mental health support and possible new solutions. From the thematic analysis of the data collected, two main themes outlined in Table B were identified: (1) barriers faced by the Muslim population in seeking mental health support and (2) what can be done to tackle barriers for Muslims seeking mental health support, these were then sorted into separate categories.

Table B - *Themes arisen from interviews*

Themes	Categories
Barriers to Seeking Support	Discrimination from Health Professionals
	Stigma Within the Muslim Community
	Ignorance and Lack of Knowledge
	Lack of Family Support
	Gender Disparity
Solutions to Tackle the Barriers	Targeting Young Muslims
	Utilising Mosques
	Offering More Talks on mental Health
	Discussing mental Health Within the Muslim Community
	Taking a Holistic Approach by Linking Iman to mental Health

Barriers to Seeking Support

Five categories were identified by participants for seeking support for mental health: participants described the barriers as being,(a) discrimination from health professionals, (b) stigma within the Muslim community, (c) ignorance and lack of knowledge, (d) lack of family support and (e) gender disparity. Participants described several different barriers which prevented them from seeking mental health support, primarily racial bias from counsellors and therapists and a language barrier which can lead to miscommunication:

"Therapists are not BAME sensitive and have biases". (Participant 3)

"[There is a] lack of understanding from therapists". (Participant 2)

Participants referred to a stigma attached to mental health and stated that it is considered taboo to seek support for mental health issues within the Muslim community:

"[There is] societal stigma for accessing [support] in the first place". (Participant 2)

Ignorance and a lack of knowledge regarding mental health were identified as a barrier by several participants:

"Denial of mental health issues as a health condition". (Participant 2)

"On a personal level, there is a lack of education and awareness from parents". (Participant 3)

A lack of family support has also prevented Muslims from accessing support:

"Limited support from family and friends". (Participant 5)

Participants articulated gender disparity as an obstacle in accessing support, being a Muslim woman was stated as facing greater stigma in seeking support:

"Choosing where to go, women's organisations". (Participant 1)

Solutions to Tackle the Barriers

The participants discussed different approaches which could be used to overcome barriers for Muslims seeking mental health support, in particular, five categories were identified: (a) targeting young Muslims, (b) utilising mosques, (c) offering more talks on mental health, (d) discussing mental health within the Muslim community and (e) taking a holistic approach by linking iman to mental health. Reaching out to young Muslims via schools and colleges could help tackle the stigma of mental health at an earlier stage in life:

"BAME [pupils] in schools and colleges should be targeted". (Participant 4)

"High schools/colleges - targeting early teens as they are most vulnerable". (Participant 5)

There is a need for mosques to play a greater role in increasing awareness and breaking the taboo of mental health issues within the Muslim community, with imams leading on this by becoming more educated on the topic of mental health:

"Mosques are key; they need to start addressing newer and contextual issues for the Muslim ummah". (Participant 2)

"Khutbahs need to be tailored/oriented more around mental health. Mental health is important for physical and emotional health, which ultimately affects spiritual health which is what mosques are for". (Participant 7)

"We need to normalise mental health within the mosques". (Participant 8)

However, there may be issues with relying solely on mosques to improve the Muslim population accessing mental health services:

"Mosques may not be the best way forward for mental health support as will push dogmatic themes and tend to be male-dominated". (Participant 4)

Increasing the number of talks on mental health would also normalise mental health within the Muslim population:

"Increase the number of speakers to help people get better and be creative with story-telling". (Participant 9)

"More talks should be given by well-known speakers (Mufti Menk etc)". (Participant 6)

Discussing mental health within the community would normalise it and enable Muslims to seek support:

"Mental health should be discussed in community centres and at events". (Participant 7)

"Peer support in communities". (Participant 1)

Taking a more holistic approach in linking iman to mental health such as using examples from the Prophet (PBUH) and the Sahaba was discussed by several participants:

"Holistic approach between Iman and scientific/biological side – backed from a religious point of view". (Participant 6)

"Linking mindfulness to Islam". (Participant 8)

Discussion

The present study was designed to gain an understanding of the perceived barriers Muslims face when accessing mental health support. In doing so, the research sought to see if webinars held by Inspirited Mind could enhance the awareness and understanding of mental health of a person and whether they could help resolve the barriers that discourage Muslims from seeking support. The research also aimed to recognise the challenges faced when people from Muslim backgrounds seek mental health support and whether they are in line with previous research that is related to Muslims seeking help.

The findings showed that the IM webinars had a positive effect on helping people become aware of the support that is open to this community. It shows the significance of providing resources that enable the public to enhance their understanding of mental health, as this will influence overcoming barriers. It can thus be suggested that webinars conducted by Inspirited Minds had an effect on barriers Muslims face to obtaining support through educating, in a positive manner since it got participants thinking about the connection Islam has with mental health.

There was a reoccurring theme of how participants benefited from the webinar connecting both Islam and mental health. Muslim mental health research has shown that many Muslims still have deep concerns about modern psychiatry and many still tend to seek assistance from traditional spiritual leaders (Basit & Hamid, 2010). Therefore, as indicated by some of the participants, using well-known speakers within the Muslim community could play a role in addressing barriers to mental health treatment. As well as using the mosque to normalise mental health problems, including educating imams and beginning to address mental health problems through the use of khutbahs (sermons). Abu-Ras et al., (2008) found that imams have a crucial role in promoting mental health and being someone that individuals could turn to for both religious guidance and counselling. Imams can also educate mental health professionals on how to incorporate religion into an individual's treatment plan. Thus, it is critical for mental health professionals to be able to give service users the option of integrating religious belief into the therapeutic work.

Stigma is well-recognised as a factor in determining help-seeking behaviour and the utilisation of mental health services. Consistent with the literature, stigma was commonly discussed as a barrier that hinders the seeking of mental health support (Al-Adawi et al., 2002; Aloud & Rathur, 2009). Within this overarching theme participants also discussed the lack of education and acceptance of mental health problems within the broader Muslim community (Ahmad et al., 2016). This may help to explain why many Muslims prefer to seek help from within their family or community (Aloud & Rathur, 2009). Psychoeducation is, therefore, a priority when providing mental health support.

The relationship between service users and mental health professional is a key factor in the overall experience of accessing services (Memon et al., 2016). Participants discussed how practitioners in mental health often have cultural prejudices and lack of awareness and understanding of an individual's religion, which plays a major barrier to seeking support for mental health. Mental health services need to consider providing culturally responsive services, taking into consideration both the cultural and religious belief of a service user into the therapeutic work (Amri & Bemak, 2013).

A possible explanation for difficulties Muslims may experience in seeking support is an underrepresentation of Muslims in the mental health field (Ragavan, 2018), including the inability to find a Muslim therapist as highlighted by participants. Language barriers and lack of support from family and friends were also common barriers discussed within the participant group.

As hypothesised, Basit and Hamid (2010) review of barriers Muslim face when trying to access support for mental health are closely comparable to those within this research. The barriers identified could explain the lack underrepresentation of Muslims within the mental health statistics (Mental Health Foundation, 2016), and therefore strengthening the validity that further work needs to be done in enabling this minority group within the UK to be able to access mental health support. It indicates that these obstacles are still prevalent, despite a 10-year difference between both studies.

Strengths and Limitations

Whilst the present study contributes to this area of research, some limitations must be considered. In particular, there may have been a sampling bias. For instance, the study only includes those that would have been aware of IM. The low response rate is another limitation, with a significant decline in response in the post-webinar questionnaire. Only a small number of participants agreed to be interviewed to gain further detailed information. Consequently, this limits the generalisability of the current results.

The participant pool consisted of over 50% of those from a South Asian background, meaning that it is not necessarily representative of the Muslim population. Within the Muslim community, there are cultural differences which in itself comes with additional barriers (Ciftci, 2012). South Asians, however, make up 68% of the largest Muslim community in the UK (Ali, 2015), and so it can be argued that it is representative in that regard. In addition, as most mental health research on Muslim participants appears to be from a South Asian background, this is in line with previous research (Ali et al., 2017; Khalifa et al., 2011; Pilkington et al., 2012).

This research has provided some rich qualitative and quantitative evidence that helps to explain why individuals within the Muslim community may not seek support for their mental health. Although certain limitations may be placed by the small sample size, the recruited participants are from minority communities and thus contribute to the often underrepresented demographic of mental health services and research (Mental Health Foundation, 2016). Particularly, to UK research as many studies conducted in this area is carried out in the US or the Middle East (Al-Adawi et al., 2002; Basit & Hamid, 2010).

Implications

This study provides further insights into the barriers Muslims may experience when seeking help for their mental health. This could be used to build tailored training to help practitioners in mental health deliver effective cultural care, which could minimise mistrust. Psychoeducation could be effective in reducing the stigma attached to mental health. Possible strategies can include providing mental health support in statutory and non-statutory services in a wide range of settings such as educational institutions, Muslim community centres, Muslim charities and mosques. It also calls for policymakers to continue developing guidelines that will enable a framework that better meets the needs of this population.

Conclusion

Our results helped identify barriers that are present when seeking mental health support. The pre and post-webinar data highlight that the use of Islamic knowledge to promote mental health helps people to be more open to seeking support. Clinicians should be open to incorporate religious perspective for service users that consider it as an important part of their treatment and recovery.

To be able to provide more in-depth insight into the barriers to mental health support, potential research should undertake similar research on a larger scale. Future research should consider gender and age groups to see if the barriers would differ, depending on an individual's demographic information. Additionally, research where religious leaders and mental health professional work collaboratively should be explored to see whether that helps to increase accessibility.

Hiring mental health professionals who are more culturally sensitive and can communicate with members of the Muslim community may be one potential way of addressing the lack of Muslims seeking help for their mental health problems. This may encourage individuals from Muslim backgrounds to have access to experts with whom they could trust and identify. This can reduce the possible stigma that is felt when seeking help from mental health services.

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