Muslim mental health inequalities – Addressing mental health through Islamic counselling a faith-based therapeutic intervention

Abstract

The chapter considers the relationship between faith, mental health and mental illness in Muslim communities. The focus of the chapter is on common mental health problems such as anxiety, depression and PTSD and their social contexts within Muslim communities. It considers the significance of the Islamic faith to Muslims, concerning its function as a 'cognitive schema' within Muslim communities enabling interpretation of experience and mental wellbeing. In doing so it will challenge current thinking regarding mental illness seen through a bio-psychosocial model. It will also explore the impact of religious or spiritual belief through an extended bio-psychosocial spiritual model. The chapter will take into consideration some of the systemic limitations that exist in mental health service provision and mental health understanding as they apply to Muslim communities including implications of Islamophobia. In this context, it will present a one-year prior one-year post evaluation of the impact on Muslim mental health of Islamic counselling (a faith-based therapeutic model) practised in a primary care context with Muslims experiencing common mental health problems co-morbid with long term physical health conditions in relation to patient use of secondary care. This identified an 82% reduction in secondary health care use across all categories in patients following Islamic counselling. The chapter will also consider research on Muslim mental health.

Understanding the relationships of faith, experience and mental health in UK Muslim communities

Little emphasis is placed on mental health in comparison with physical health both concerning health provision in general and specifically regarding the wellbeing of Muslim communities. For this reason, there is a need to highlight concerns about Muslim mental health for Muslim communities themselves, as well as for policymakers, commissioners and service providers. 1.8 billion people globally are Muslim and so share the belief system Islam through which they interpret their experience of self and reality. There is a need to draw attention to the inequalities experienced by Muslims in the context of the present lack of equality of appropriate provision in mental health care.

Faith or religion is not a common point to start considering mental wellbeing. Social, as opposed to biological determinants of mental health are generally based in cultural contexts (World Health Organization and Calouste Gulbenkian Foundation 2014) and faith or religion in itself is not considered a critical factor. As social determinants of mental health are primarily understood within cultural paradigms, these are often reduced to ethnicity. Much of the thinking in the UK about social policy and service provision is implicitly secular. Let us start by understanding religion as:

> …a social identity that is grounded in a system of guiding beliefs, and may serve as a powerful tool to shape psychological and social processes (Ysseldyk, Matheson & Anisman, 2010).

Research has shown that in and of itself, religion contributes to the experience of greater positive and fewer negative emotions for the people who believe in it (Kim-Prieto & Diener, 2009). However, despite a significant amount of data gathered about the relationship between faith and mental health, much of this concerns Christianity (Cornah, D., 2006). Christianity has a long historical impact on Western thinking and is fundamentally linked to Aristotelian epistemology in the development of the sciences.

Islam being not classically 'European' however generates a different perspective on reality. Though it is often considered as a religion in Western contexts, within its own context Islam is the 'deen'. *Deen* does not accurately translate as religion. "(Madhhab is the Arabic word for religion.)" The deen can be seen to have multiple meanings in various contexts. These include the way, governance and judgement. These all relate to the life transaction between humans and the Creator (Esposito 2014). Islam is then a way of being which grounds experience, identity and conception within a frame of reality defined by this transaction. It is both absolute and relative, adaptive and contextual and at the same time universal and true.

In light of the above Islam can be understood as a fundamental 'cognitive schema'. Here reality is held in a way that allows for experience and knowledge including scientific empirical knowledge to be held in a greater context of Ilm, (Knowledge as understood in Islam). Here there isn't a duality between the scientific knowledge and divine knowledge, just different degrees and ways of things being known. This allows flexibility in experiencing life phenomenologically and through rational observation, allowing for the coexistence of realities that others find contradictory.

Muslims have many interpretations of Islam. Practices such as Shia-ism, Sufism, Sunnism, liberal Islam, conservative Islam, practicing and not practicing Islam each impact on how individuals and groups construct value and meaning within lived experience. These understandings of reality interact and come to bear on the construction of self-worth, emotional resilience, and the interpretation of experience and enabling many Muslims to maintain their psychological integrity in adverse conditions as is the case in other communities defined by spirituality or religion (Koenig 2012).

Muslim communities are faith communities existing as coherent bodies based on shared networks of belief. Being part of the Abrahamic tradition, they relate to Christian and post-Christian rational empiricism though in some respects relationships with empiricism may be distinct.

This is not to say that there is a conflict with the main body of western thought, nor that they are better or worse, simply different. Similarly, as western thought has its nuances so too does Islamic thought.

The cumulative history of western thinking has shaped the thoughts, beliefs and core concepts of its mental health professionals and therapeutic models alike. The cumulative history of Islamic thinking has shaped the psychological reality of Muslims. An example of the way these distinctions impact on mental wellbeing and therapeutic interventions is the greater western emphasis on thought and action as seen in the emphasis in cognitive *behavioural* therapy compared with an Islamic emphasis on being, as seen in the emphasis on the state of the heart[1] as within Islamic counselling and psychology (Frager, R., 1999). Also, identity in Muslim culture and Islam, in general, as with many eastern religions and philosophies, is defined more in terms of relationships - it is less individualistic than many Northern European conceptions (Oyserman, D., & Lee, S. W. S. (2008). Northern European individualism can be a factor Muslims grapple with living in the UK as it impacts differently across generations. Competing understandings of self and family mean that well-intended therapeutic interventions may undermine and challenge self-concepts that are core to the client's identity.

Western and Islamic thought create different narratives of reality requiring Muslims living in the UK, as well as the mental health practitioners who work with them to understand both. Muslims must be cultural navigators regarding their faith and British modernity (Considine, C., 2018).

Current Health Practice regarding Muslim mental wellbeing – decision making, data and ethno-religious identification

The life transaction of 'being Muslim' impacts Muslim conceptions and experiences of reality, with this it is important to consider how such faith-based inner worlds are met within the field of mental health.

The Department of Health and Social Care has statutory duties under the Equality Act 2010, requiring it when making decisions to take into account the need to:

- eliminate discrimination, harassment and victimisation
- advance equality of opportunity

[1] The significance of the heart and intentionality does not contradict the generally understood importance of Islamic law but is an a priori. The following hadith indicate the significance of the condition of the heart and intention. "Beware, in the body there is a flesh; if it is sound, the whole body is sound, and if it is corrupt, the whole body is corrupt, and behold, it is the heart." (Al-Bukhari and Muslim) Hadith Number 6 An Nawawi's 40 Hadith. "All actions are judged by motives, and each person will be rewarded according to their intention. Thus, he whose migration was to God and His Messenger, his migration is to God and His Messenger; but he whose migration was for some worldly thing he might gain, or for a wife he might marry, his migration is to that for which he migrated." (*Saheeh Al-Bukhari, Saheeh Muslim*) Hadith Number 1 An Nawawi's 40 Hadith.

- foster good relations between different parts of the community

These requirements are across the protected characteristics of, age, disability, gender reassignment, marital or civil partnership status, pregnancy and motherhood, race (including ethnic or national origin, colour and nationality), religion or belief (including lack of belief), sex and sexual orientation'.

The needs of faith communities generally have remained invisible in planning and service provision. To date, there has been a lack of recorded focus on religion or belief as a protected characteristic compared to the others. This has been the case in health-related planning, service development and service delivery in general[2]. In the absence of clear direction from the Department of Health and Social Care, inaction concerning the statutory duty regarding religion and belief is also evident in decision making of bodies such as NHS England specifically about Muslim mental health and related services. Much of mental illness is social in origin not genetic, often a response to life events and or negative conceptions of self-worth. Mental health provision has adopted a bio-psycho-social model of understanding mental ill-health not recognising the significance of faith.

> Therapeutic recovery, however, is a ***personal process*** related to the restoration of the ability to function within the contextual environment and the establishment of value and autonomy for the individual through a process that is valid for them. Much of this comes back to identity and belief.

Muslims are self-defining communities that see their critical point of referencing identity as their faith (Maynard 2007). Muslim communities in the UK are ethnically diverse including members originating from across at least 5 continents. However, in the context of such diversity ethno-religious assumptions and identifications often subsume the faith identity of Muslims in health policy and service provision. Approximately 60% of the British Muslims are of Pakistani, Bangladeshi or Indian origin. This proportion is decreasing over time as ethnic diversity has been increasing with more Muslims origination from Black African Black other and Asian other

[2] This problem is indicated in the following, though the Department of Health and Social Care's No health without mental health: Cross-Government Mental Health Strategy for People of All Ages (2012) identifies its commitment to the 2010 Equalities Act including religion and belief and commits to reducing mental Health inequalities in line with this, the actual No health without mental health implementation framework, only acknowledges religious belief in respect to the department's responsibilities under the Act giving no guidance for strategy regarding how government departments will plan concerning religion and belief. Following on from this the current NHS England strategy for Mental Health, The Five Year Forward View for Mental Health, does not refer to faith belief or religion whilst addressing ethnicity, sex, age, sexual orientation, pregnancy, motherhood. Further, the current NHS Scotland mental health strategy, Mental Health Strategy 2017-2027 and the current NHS Wales mental health strategy, Together for Mental Health Delivery Plan 2019-2022 do not refer to faith, religion or religious belief. The Health Northern Ireland Service Framework for Mental Health and Wellbeing 2018-2021 does however commit to providing services to all irrespective of religious belief, perhaps this is due to the historic and political context.

origins (Census 2001. ONS Table S104 & Census 2011. ONS Table DC2201EW). However, with the history of thinking about ethnicity in health planning and the lack of data collected on faith, Muslim identity is not seen in most mental health provision and is considered addressed in 'working with' the Asian or the Pakistani community. This process not only renders significant proportions of the Muslim community invisible, but it also bypasses the identity and lived reality of the service user preventing active consideration of how Islam structures experience.

In her 2005 paper Mir examined the impact of the 2 predominant European conceptual frameworks regarding Muslim identity on health and healthcare, namely:

> 1, The Enlightenment notion, that religion is a private matter to be disassociated from public life, particularly from the scientific enterprise.
> 2, The Orientalist tradition, of portraying Islam as inferior to Western culture and Muslims as people to be feared and controlled.

Mir identified…

> "that dominant conceptualisations of religion and of Islam corrupt the communication process between Pakistani people and health practitioners; discussion of religious influences on self-care is avoided by patients and practitioners alike and Pakistani people are exposed to stereotypical ideas about their beliefs and practices. Consequently, they receive inadequate support in decision-making about chronic illness management and are more likely to develop complications. This disadvantage is exacerbated by ethnicity and gender."

> "The disadvantage to which Muslim identity appears to expose individuals and groups suggests a possible explanation for higher levels of mortality and morbidity within this community compared to other minority ethnic communities."

With regards to clinical practice, policy research and engagement with Muslim communities concerning health Mir argues for…

> "Developing shared understanding and common ground with Muslim perspectives is highlighted as a necessary focus for policy and practice development. Policy support for Muslims to organise on the basis of faith identity is also indicated if health inequalities within the Pakistani Muslim community are to be effectively addressed."

In the presence of the two assumptions identified by Mir and the absence of an understanding of Muslim faith-based identity in statutory mental health provision, ethno-religious assumptions prevent the collection of data relevant to developing an understanding of mental health within specifically Muslim communities. The assumption is that ethnic data collected on the Pakistani community provides the same information. However, this has implications. Data that is collected and examined about ethnicity is interrogated from within that frame of reference. Ethnicity or race is seen as 'the' significant factor concerning findings from the data regarding assessment, treatment and service delivery. This means that practitioners focus on ethnically

defined cultural competence as the most significant way to deliver appropriate services to diverse communities. Culture and ethnicity are relevant factors in consideration of the wellbeing of a distinct community. But where is the evidence, that the dyad ethnicity and culture defined by place of origin are the most significant driving factors that need to be taken into consideration to account for health inequalities in ethnically diverse communities such as Muslims? Such identification can be irrelevant through its lack of precision. Consider for example the ethnic identifiers Asian or Black African which refer to diverse peoples in the UK who originate from continents in which 1500 to 2300 different languages are spoken.

There appears to be recognition that Pakistanis (and implicitly Muslims) like other minority communities experience mental health inequalities. But even when data is collected concerning faith rather than ethnicity the data is limited. There also is a lack of analysis regarding significant factors about mental health need, appropriate treatments or health outcomes that correlate with this difference. The National programme Increasing Access to Psychological Therapies (IAPT) is core to mental health strategy in England the Five Year Forward View for Mental Health IAPT does monitor the faith of patients receiving treatment. Outcomes data repeatedly shows that Muslims experience poorer outcomes from this strategy though no counter measures are proposed.

The National Strategy for Mental Health within NHS England does not refer to faith, religion or belief. This lack of consideration of religion or belief in the strategic planning of mental health provision for England may have practice implications related to Muslim identity and mental health concerning either:

- Unidentified external stressors contributing to mental illness within Muslim communities such as Islamophobia (M Ahmer 2011),
- Preventing engaging in more effective treatments through working with faith-based internal resilience to mental illness such as that evidenced in research relating to faith and mental health (D Cornah 2006),
- Biased consideration of faith beliefs and clients related interpretations of experience creating obstacles to the effective application of standard treatments (G Mir 2005),
- Missed opportunities for the development of personalised appropriate treatments (for example the incorporation of Islamic counselling in treatment regimens and or research trials).

As significant proportions of Muslim communities ethnically are of Black, Asian or minority ethnic communities, the situation within the NHS is further exacerbated by Black and South Asian patients being less likely to have mental health problems recognized by their GP (Gillam et al. 1989; Odell et al. 1997; Bhui et al. 2001). GPs may also experience South Asian patients as somaticizing their condition making the presentation of some mental health problems unclear. In a small study carried out in a GP surgery with a majority of 70% Muslim patients, research found that frequent attenders at this practice from Muslim Pakistani and Pashtun (Afghanistan/ Pakistan border) backgrounds had high rates of psychological distress (Fazil et al 2004).

It is also important to consider the role of The National Institute for Health and Care Clinical Excellence (NICE) regarding Muslim mental health. NICE through its guidance sets standards of practice for health provision nationally. Such guidance includes the 2018:

> NICE 2018. Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups Quality Standard

Again, here emphasis is placed on ethnicity not religion or belief. There is not a separate NICE Quality Standard that considers religion and belief in this way.

Even regarding ethnicity, at the time of writing this chapter, NICE is revising its guidance on adult depression following consultation. The circulated draft guidelines referred to DSM-5 in its recommendations regarding assessment. However, no mention was made of DSM-5[3] supplements regarding the (new) Cultural Formulation Interview (CFI). The CFI assesses both cultural or ethnic groups that the patient belongs to and how group understandings and experiences may impact the subject's experience of wellbeing. In the absence of such a reference in NICE guidelines, it is unlikely that the CFI would be widely used by mental health practitioners here. Further, the confusion of the NICE position on ethnicity is demonstrated by unclear and inconsistent requirements. The NICE guidelines 'Depression in children and young people: identification and management (CG28)' state:

> Healthcare professionals in primary care, schools and other relevant community settings should be trained to detect symptoms of depression and to assess children and young people who may be at risk of depression. Training should include the evaluation of… *ethnic and cultural factors*...[2005]
>
> Child and Adolescent Mental Health Services (CAMHS) tier 2 or 3 should work with health and social care professionals in primary care, schools and other relevant community settings to provide training and *develop ethnically and culturally sensitive systems for detecting*, assessing, supporting and referring children and young people who are either depressed or at significant risk of becoming depressed.
>
> &
>
> Healthcare professionals in primary, secondary and relevant community settings *should be trained in cultural competence to aid in the diagnosis and treatment of depression in children and young people* from black and minority ethnic groups.

[3] The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition is the 2013 update to the Diagnostic and Statistical Manual of Mental Disorders, the taxonomic and diagnostic tool published by the American Psychiatric Association in the United States of America.

This importance given to awareness of cultural factors in the assessment and treatment of depression in children is not evident in the assessment of adults (as would be indicated by the use of the CFI in adults). Further regarding children, no guidance is given as to what such awareness would entail, to what standard it should be expected or how it should be gained. NICE guidance concerning ethnicity across ages appears confused and regarding religion and belief absent.

Detailed consideration of the way that statutory services interact with Muslim clients is essential in understanding Muslim mental health. The most effective means of addressing many mental health problems is through talking therapies which require the counsellor or therapist and the client or patient to develop a working alliance based on rapport. Muslim clients in addition to being of a specific faith that is most often different to that of the counsellor may also be of a different class to their counsellor. The majority of Muslims being BAME and the majority of counsellors being white European also means that they are often of a different ethnicity to their counsellor. These differences imply that the core faith identity of the client their race or class are easily not engaged with. The outcome of this is the degree to which the Muslim client is generally disabled or enabled in the therapeutic relationship. Over the last 40 years, whilst much has been written about ways of actively engaging people of colour in therapy regarding mental health, in the same time this parallel problem of the relationship between Muslim clients and mental health interventions remains largely unconsidered. It is also important to recognise in this context the cultural significance of wider geopolitical factors (for example forced migration) regarding Muslim identity in the UK, and how these impact on the wellbeing and mental health of the individuals and Muslim communities. Being Muslim in the UK for many includes the reality of being a refugee. It also includes the significance of living in a post 9/11 context and the questioning this engenders for a person following the faith of Islam.

Counsellors and therapists need to be able to empathetically navigate the development of rapport to work effectively – this is not assisted by obfuscating people's faith-based self-conceptions and understandings of reality by ethnic identities which may externally impose inaccurate or less significant identifiers to the client through ethno-religious identification.

This is significant in the context of the Department of Health and Social Care's contribution to the Governments Prevent Strategy particularly for health care workers. The UK is the only country worldwide to embed counter-terrorism into Health and Social Care. 2018 research from Warwick University on the use of PREVENT in the NHS found that mental health professionals were unclear regarding what their role was or how to assess the risk of radicalisation. The research found some cases of mental health professionals referring people to Prevent for watching TV in Arabic or going to Mecca for the Islamic pilgrimage.

Ethno-religious identification and the current political climate reduces the possibility for faith to be explored as a positive factor concerning Muslim mental health. It also creates barriers to researching and evidencing any relationship between faith and condition or faith and treatment. This lack of information gathering regarding faith and condition is of specific

importance in the UK at a time of heightened religious hatred evidenced by the increase in hate-based crime recorded by the police concerning Muslim communities (BBC 2018). In this context key questions are not considered strategically such as:

What is the psychological impact of increased violence on Muslims?
How is it internally /psychologically represented?
Does that impact on the incidence of anxiety?
Or how well will a therapeutic model (which at its core rationally interrogates the belief and understandings of its clients to dismiss myths) practised by mental health professionals without understanding of faith-based beliefs within Muslim communities facilitate long term mental health improvement?

Islamic counselling, an evaluation

The following is an evaluation of a faith-based therapeutic intervention used in an NHS setting with Muslims experiencing common mental health problems. Islamic counselling is a developing modality of therapeutic counselling practiced in the UK for over 20 years[4]. This is work that has been developed by Sabnum Dharamsi and the author of this chapter. It has a clear theoretical base derived from Islamic teachings as opposed to models that are hybrids or adaptations of contemporary therapeutic models and Islam. This differentiates this work from a number of other therapeutic practices that in the last 20 years that have also adopted the same name. For this reason, all further references to Islamic counselling will be to this model. Islamic counselling's aim is to enable people to develop and grow, through finding a path of balance, through their reflections on their experiences and themselves. Islamic counselling is derived from Quranic verses, Hadith and the teachings of Tasawwuf the Islamic science of the self.[5]

[4] Islamic counselling, Islamic psychotherapy, as interrelated fields have been developing over the last 29 years. The term Islamic counselling was first coined by Aliya Haeri who with Shaykh Fadhlalla Haeri developed the initial model based on Islamic teachings in the science of Tasawwuf into a contemporary therapeutic approach. This work was then taken on by Sabnum Dharamsi and the author who since 1996 have developed the model, established Counselling and Psychotherapy Central Awarding Body accredited training programmes since 1998 to level 5 and developed Islamic counselling services. Dharamsi and Maynard have published regarding this work, there are trained professional Islamic counsellors competent in this model in practice. This paper presents evidence of the efficacy of this model. Numerous conference presentations and papers by Dharamsi and the author have presented the methodology as well as aetiology of mental health problems and human development from the Islamic counselling perspective.

[5] Islamic counselling is distinct from culturally appropriate models of counselling Muslims based on cultural similarity between counsellor and client, or, the integration of Islamic teachings or quotes into alternate contemporary therapeutic models or the 'cultural competence' of counsellor or therapist. Though all approaches to Islamic counselling start from Quran and Hadith in the 2007 Department of Health Muslim Mental Health Scoping Report the author identified the two broad approaches to Islamic counselling intrinsically rooted in Islamic teachings, those being Islamic counselling models that are derived from Tibb medicine (the medicine of the last prophet), and those derived from Tasawwuf. The model discussed in this chapter is based in Tasawwuf. Further information on this model of Islamic counselling can be found in Maynard, A., 1998. Beginning at the Beginning Islamic Counselling, Race

Islamic counselling has been taught through accredited training to the level of a professional qualification for 20 years. It has been provided as a therapeutic intervention in partnership with the NHS to Muslim communities in London or Birmingham since 2002 and by a small pool of Islamic counsellors working in other contexts. The following evaluation relates the work of Islamic counsellors at the Lateef Project and its partnership from 2011 with the Pearl Medical Centre in Birmingham.

The Lateef Project is an Islamic counselling service developed to work with Muslim communities in Birmingham following on from the Department of Health and Social Care Muslim Mental Health Scoping Report (2007). After its first year providing a telephone-based service in partnership with the local Mental Health Trust, the Lateef Project entered into the provision of an embedded counselling service at Pearl Medical Centre, a surgery with 10,000 patients 7000 of which are Muslim. This work was independently externally evaluated for the first year.

Pearl Medical Centre is located in Washwood Heath. It serves a diverse community mostly originating from Pakistan or Afghanistan, many of whom live in relative deprivation. Here common mental health conditions frequently related to at least one of the following factors:

- Islamophobia and racism or,
- histories of trauma related to domestic violence,
- histories of child sexual abuse or neglect,
- PTSD from these or other forms violence including the experience of war among refugees and asylum seekers as well as within established communities that have experienced war,
- Forced marriage,
- Substance misuse related to depression.

Patients often presented with a mental health problem (most often anxiety with depression) co-morbid with a long term condition (LTC) such as cardiovascular disease, diabetes or chronic obstructive pulmonary disease (COPD). There were also presentations of a common mental health problem co-morbid with medically unexplained symptoms (MUS) or somatic symptoms. These themes of co-morbidity coincided with these patients presenting frequently to the surgery each year.

This cohort of patients with complex co-morbid presentations were identified as a target group to enable the evaluation of the impact of Islamic counselling. Medically unexplained symptoms research evidence indicates that MUS accounts for up to 20% of GP consultations and is associated with 20-50% more outpatient costs as well as 30% more hospitalisation (Simon,

---

and Cultural Education in Counselling Multi-Cultural Journal BACP No 16 Summer 1998; Maynard, S., 2007. Muslim Mental Health: A Scoping Paper on theoretical models, practice and related concerns in Muslim Communities; Dharamsi, S., & Maynard, A., Islamic Based Interventions in Counselling Muslims a Handbook of mental health issues and interventions Ed Ahmed, S., Amer, M., Routledge New York 2012.

2005, Simon GE, Von Korff M 1991. Steven Reid, Simon Wessely, Tim Crayford, and Matthew Hotopf. 2001, Fink P. 1992,). Relative costs to health care are also significant as co-morbid mental health problems exacerbate physical illness and complicate its treatment. This raises the total health care cost by at least 45% per person with co-morbid mental health and long-term physical health conditions. (Naylor, J., Parsonage, M., McDaid, D., Knapp, M., Fossey, M., Galea, A., 2012). There is also research (e.g. Reid, Crayford and Hotopf 2002), that demonstrates the importance of appropriate psychological interventions with such patients in reducing the frequency of attendance at secondary care as well as in improving health care.

The methodology

The evaluation of Islamic counselling was carried out over a period of 1 year starting from December 2011. An independent consultant was recruited to complete the service evaluation. Additionally secondary care appointment/ attendance/admission data collected quarterly for the period by BENPCT. As an evaluation of service, this study did not require ethical approval.

Evaluation participants were 83 adult Muslim surgery patients who were referred to the Lateef Project. They presented with a common mental health problem and either a long term physical health condition or symptoms classified as medically unexplained symptoms (MUS), and had attended the surgery over 30 times in the year before the Islamic counselling intervention. These patients had high rates of primary care attendance and high secondary care attendance. Patients diagnosed with long-term conditions were identified through primary care and tracked concerning their secondary care usage over the research period. Patients within the study reflected the gender distribution social class, age, family formation and networks common within the wider Muslim patient community of the surgery, referred on to mental health support at the time. A decision was made not to include a control group in the context of the long term service evaluation to increase the depth of analysis of Islamic counselling.

The hypotheses that were tested were as follows:

1 The consultation rate in primary care would slightly increase/be more contained for those patients within the LATEEF cohort

2 The use of secondary care (planned and unplanned) would significantly reduce for those patients within the LATEEF cohort.

It was believed that engaging with the lived reality of the patients in a way that enabled acceptance of their experience in the context of their beliefs would enable a deep therapeutic relationship through which with time resilience could be developed. This would enable them to reframe their experience of their symptoms resulting in greater psychological wellbeing, and an increased capacity to facilitate their physical wellbeing resulting in a reduced reliance on secondary care. In this context, counselling may increase patient attendance at the surgery whilst at the same time reducing attendance at secondary care.

The counselling interventions were between 8 and 16 sessions, that being equivalent to a high-intensity IAPT intervention. These took place within the normal conditions of the surgery. The cohort consisted of both men and women.

Following the data collection, the analysis included an analysis of the acute activity before and after the date of intervention for a year for each NHS number by codification, speciality, and diagnostic code.

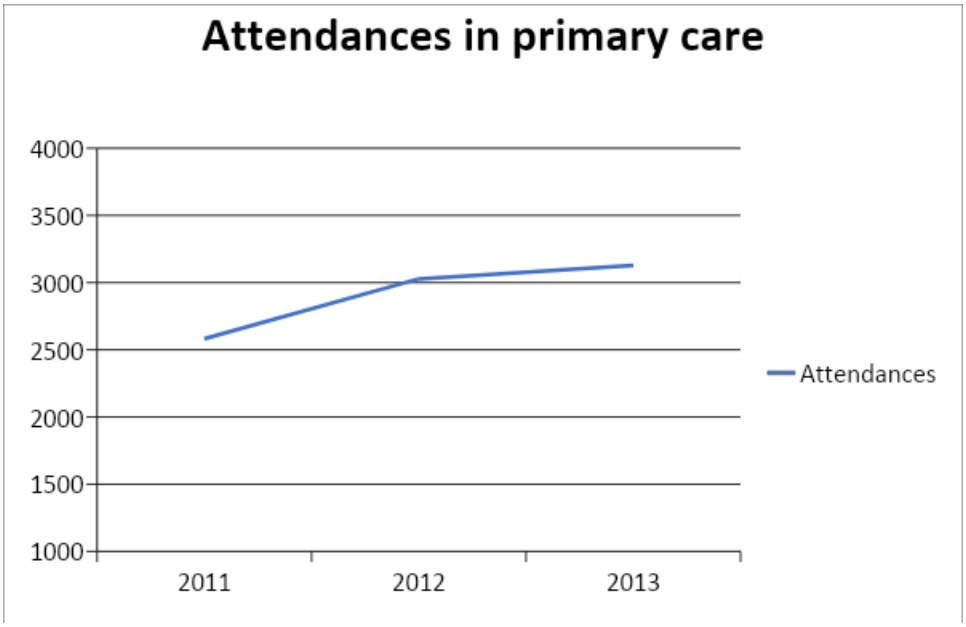
This evaluation was designed as a simple efficacy study concerning Islamic counselling. Patient secondary care activity was seen as an inverse measure of generalised patient wellbeing as well as an indication of the level of patient reliance on secondary care considering the impact of their psychological wellbeing on their physical health.

Outcomes of the evaluation concerning working hypotheses 1
Consultation rate within primary care would increase/be contained.
The attendance/consultation rate for the cohort at the surgery in 2011 (i.e. before referral) were analysed and compared to years 2012 and 2013 (i.e. after referral) using the data sources identified. Despite the small overall sample size, a small number of individuals showed a dramatic reduction in their attendance rate. The overall trend though showed an increase in patient attendance at the surgery.

Figure 1. Total Cohort attendances at surgery 2011 to 2013

YEAR	**2011**	**2012**	**2013**
ATTENDANCE	2582	3028	3127

Figure 2. Total cohort attendances at surgery 2011 to 2113 graphically



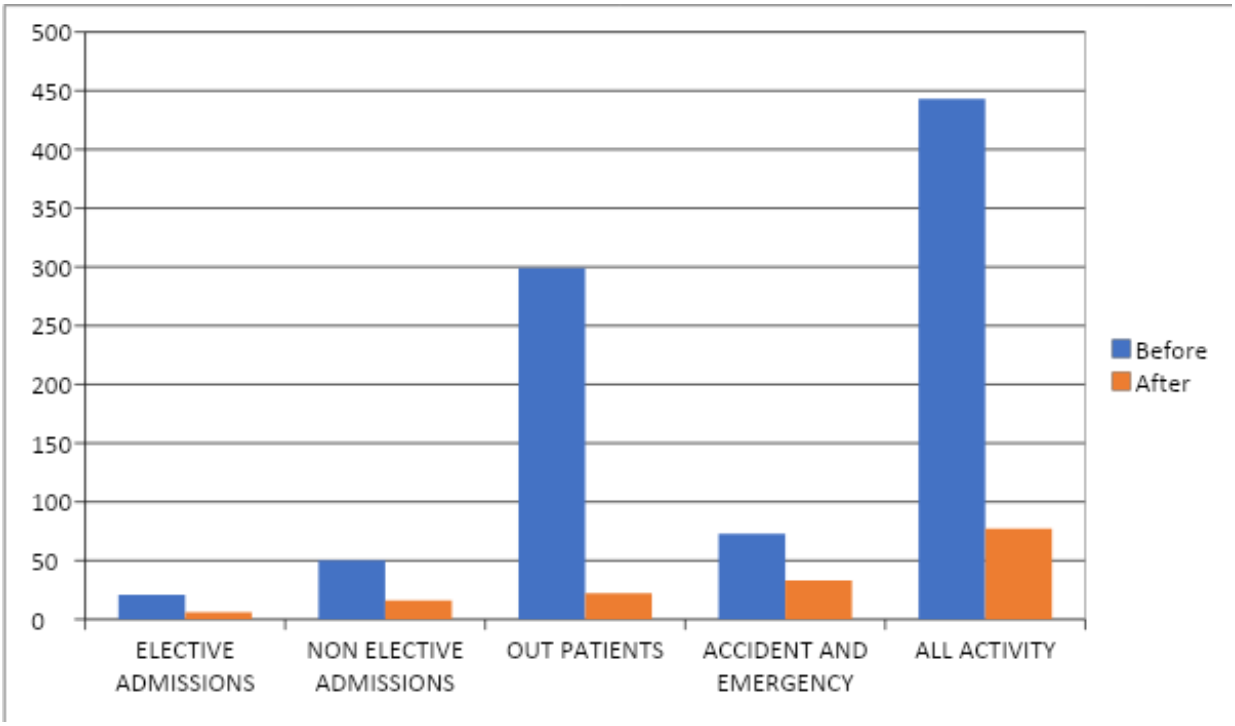
Outcomes of the evaluation concerning working hypotheses 2
Attendance rate within secondary care would significantly reduce.
Using NHS numbers the evaluation analysed the appointment/attendance/admission rate for the cohort of patients by quarter (3 months) in 2011 before referral to Islamic counselling and compared this by quarter for 4 quarters post Islamic counselling intervention.

Figure 3. Total Cohort Secondary care attendance before and after Islamic counselling intervention in figures and percentages numerically represented.

BEFORE		**AFTER**	
			PERCENTAGE CHANGE
ELECTIVE ADMISSIONS	21	6	71% REDUCTION
NON ELECTIVE ADMISSIONS	50	16	68% REDUCTION
OUTPATIENTS	299	22	92% REDUCTION
ACCIDENT AND EMERGENCY	73	33	55% REDUCTION
ALL ACTIVITY	**443**	**77**	**82% REDUCTION**

Using standard t testing at a p-value of 0.05, these results are statistically significant. The p-value for the total evaluation across all 4 conditions was 3.87698E-10. The p-value for elective admissions was 0.001672. The p-value for non-elective admissions was 0.012363. The p-value for A&E was 1.002E-7 and outpatients 0.000212.

Figure 4. Total Cohort Secondary care attendance before and after Islamic counselling intervention in figures graphically represented.

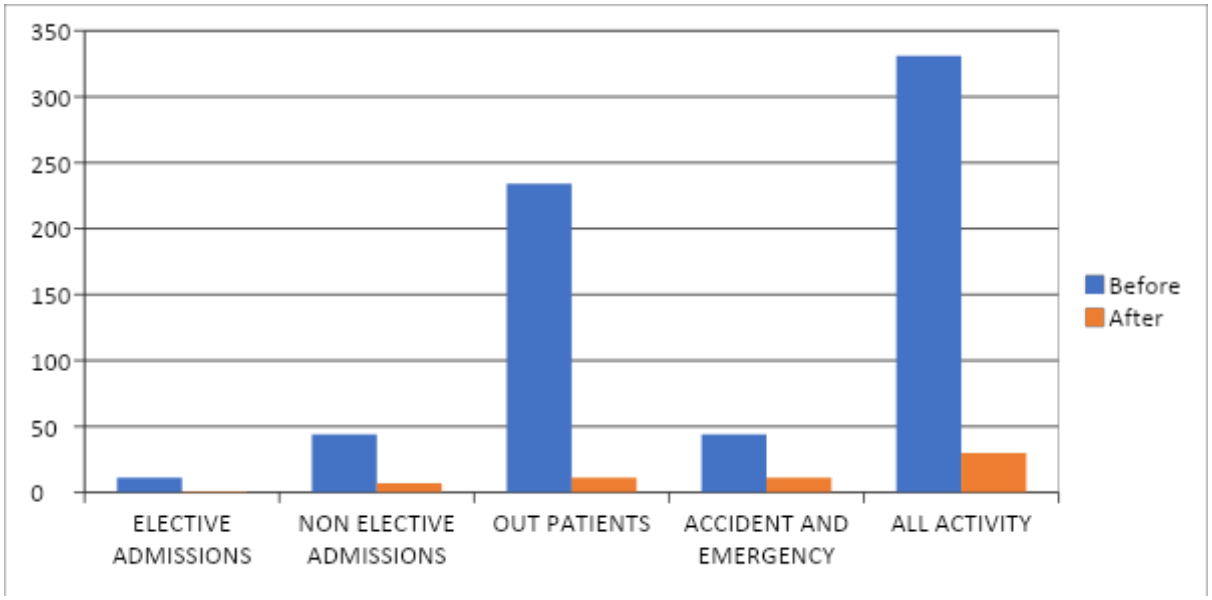


When a smaller group of patients who had attended secondary care five or more times within the year before receiving Islamic counselling were considered (sub cohort 2, 32 patients) the figures demonstrated a greater reduction in secondary care usage.

Figure 5. Sub cohort 2 Secondary care attendance before and after Islamic counselling intervention in figures and percentages numerically for patients who in the prior year had attended secondary care 5 or more times.

BEFORE		**AFTER**	
			PERCENTAGE CHANGE
ELECTIVE ADMISSIONS	11	1	91% REDUCTION
NON ELECTIVE ADMISSIONS	44	7	84% REDUCTION
OUTPATIENTS	234	11	95% REDUCTION
ACCIDENT AND EMERGENCY	44	11	75% REDUCTION
ALL ACTIVITY	**331**	**30**	**91% REDUCTION**

Figure 6. Sub cohort 2 Secondary care attendance before and after Islamic counselling intervention in figures graphically represented.



The data shown in the preceding 4 figures illustrate clearly the reductions in patient use of secondary care across all areas following Islamic counselling. As Illustrated in figures 4 and 6 the greatest reductions in patient attendance in secondary care occurred in outpatient appointments. The evaluation demonstrates changed behaviour following the therapeutic intervention. This warrants further research work towards achieving appropriate and effective shifts of Muslim patient activity from secondary to primary care on a sustainable basis. This in itself would also require greater knowledge of Muslim physical and mental health co-morbidity and understanding of both the impact of current medical practice on such co-morbidity as well as Muslim health-related decision making and behaviour (Mir, G., & Sheikh, A., 2010).

It is accepted that there could be confounding variables affecting the data, but the significance of the shift and the consistency of shift suggests a strong causal link. It is also acknowledged that appropriate targeting of patients with a particular profile/pattern of healthcare usage and presentations needs to be central to any ‘scaling up' of such work.

The evidence from this work shows that Muslims co-morbid with common mental health problems and LTC / MUS who receive Islamic counselling present patterns of reduced use of secondary care including A&E following counselling and that these patterns are present 1 year after the intervention. It should be noted that De Lusignan et al 2014 in their IAPT LTC/MUS Pathfinder Evaluation were overall unable to find changes in clinical or economic outcomes across several therapeutic interventions after 3 months.

Previous research on the impact of faith on the therapeutic relationship can assist in understanding the outcome of this evaluation. There is a considerable body of evidence that indicates that spirituality and religious identity have a direct impact on the quality of therapeutic work when working with mental health. Clients believe religious issues are generally appropriate in the counselling session and even display a preference for discussing spiritual

and/or religious concerns (Rose, Westefield & Ansley, 2001). In another study 81% of respondents wanted counsellors to integrate beliefs and values into therapy (Kelly, 1995). Where clients had spiritual or religious discussions in counselling, most clients report that they were responsible for initiating these conversations (Morrison et al., 2009). Christians and members of other religions prefer counsellor beliefs to be similar to their own (Guinee & Tracey, 1997), believing that counsellors with similar beliefs are more likely to support their beliefs, rather than challenge those beliefs. Challenging produces fear because clients are worried psychotherapists will try to alter beliefs and convert the client to their religion (Quackenbos, Privette & Keintz, 1985). Belaire and Young (2000) studied the influences of spirituality on counsellor selection and found that while client spirituality may have less influence over counsellor selection, counsellor ability to effectively implement religion and spirituality into counselling affects client preference of counsellors.

Considering the evidence above, enabling Muslim clients to be in therapeutic relationships that hold their reality both experientially and spiritually would appear to have a direct positive impact on the outcome of the therapeutic relationship in the complex and difficult settings evaluated in the above work.

In this context, it can be argued that a therapeutic model that enables the spiritual reality of the client to be part of the framework of their understanding of the self, situation and wellbeing, enables them to bring to the therapeutic relationship their spiritual resilience and understanding of reality as powerful tools supporting resilience in addressing wellbeing in complex contexts. At this time the author is aware of no other evidence of the efficacy of Islamic counselling or Islamic psychotherapy models. Verification of the therapeutic impact of this and other interventions is important to the mental wellbeing of Muslims in the UK and globally.

Research indications of Muslim mental health inequalities

To understand the implications of this evaluation it is necessary to develop a wider understanding of Muslim mental health. As previously explained, this is difficult as much of the information regarding Muslim mental health has to be extrapolated from ethnic identification. Some work specifically focusses on Muslim mental health. There is also data collected in Muslim majority countries or among Muslim minorities elsewhere. Altalib, Elzamzamy, Fattah, Ali and Awaad (2019) mapped global Muslim mental health research trends from 2000 to 2015:

> "The common theme of the MMH (*Muslim mental health*) literature is that Islam as a religion often informs how emotional distress is conceptualized and expressed, shapes interpersonal roles and relationships, and impacts health-seeking behavior in Muslim subcultures."

This supports engaging with faith and spirituality in the provision of mental health treatments. However, they also found that:

> "The volume of MMH research is grossly disproportionate to the global Muslim population. For instance, the total number of MMH articles globally is less than the number of mental health publications of many individual academic institutions in the USA and UK during the same period (and not related to MMH)."

> "Original research on the role of Islam and Muslim culture on the expression of and coping with emotional distress constitutes <5% of the MMH literature and is primarily published by researchers based in medium- and high-income Muslim-majority countries such as Turkey, Iran, and Malaysia."

They also report:

> "MMH research themes topics related to 'trauma', 'violence', 'war', and post-traumatic stress were the most prominent. Other common psychiatric topics such as generalised anxiety disorders, substance use, and psychotic disorders were not prominently represented across regions. By contrast, in the more general mental health literature, substance abuse, depression, anxiety, psychotic disorders, and dementia are prominently featured across countries' mental health research."

Finally:

> "Further research in basic mental health needs, access to services, and effectiveness of MHS (*mental health service*) delivery to the nearly two billion Muslims globally is greatly needed."

Accepting the limitations of the research the following papers present themes indicative of complexities of Muslim mental health, which describe a distinct profile of Mental health service needs that remain unaddressed in generic provision.

According to UNHCR figures from 2017, globally 68% of the world's refugees originated from Syria, Afghanistan South Sudan, Myanmar or Somalia; three of these countries have significant Muslim majority populations and 1.2 million Muslims left Myanmar due to religious persecution. In the UK a significant proportion of refugees are Muslim. People of refugee background experience multiple forms of disadvantage, including rates of long-term physical and psychological problems that are more significant than for other immigrants (Victorian Refugee Health Network, 2009; Department of Human Services, 2008). People of refugee background are also known to be at higher risk of suicide (Baron, 2002; Vijayakumar & Jotheeswaran, 2010).

Where prevalence studies exist reviews of these (e.g. Davidson, Murray & Schweitzer, 2008; Fazel, Wheeler & Danesh, 2005; Gerritsen et al., 2004) show a huge range in reported mental

health disorder prevalence rates among people of refugee background, due to the heterogeneity (especially sample size) of the study population, the measurement instruments and process (e.g. interviewer non-native to the refugee's ethnic group as opposed to native). The prevalence rates for depression range from 2% to 88% and from 3% to 86% for post-traumatic stress disorder (PTSD). Similar percentages are reported for the prevalence of anxiety (2% to 80%).

With a significant proportion of Muslims refugees having escaped from regions of conflict, the Gupta, Falb, Carliner, Hossain, Kpebo, & Annan (2014) paper on the relationship between armed conflict, domestic violence and probable PTSD among women in the Ivory Coast, (a country where the largest religious group is Muslim - 39%) is of note. Their study indicated that domestic violence is more strongly associated with past-week probable PTSD than remote domestic violence directly related to the crisis. Not only did the authors identify a relationship between probable PTSD, conflict and domestic violence they argue that:

> '…domestic violence in such contexts must be considered within humanitarian mental health and psychosocial programming.'

Here there is a frightening sense that traumatised people who have been brutalised will commonly perpetrate and or be victims of domestic violence.

Concerns regarding Muslim Women and mental health have been in discussion for 30 years in UK healthcare. These include the high prevalence of suicidal behaviour and ideation among Asian Adolescent females (Bhugra 2002). Recent concerns also include the relationship between domestic violence and mental health problems and the relationship between Muslim women's mental health and the wider family context as mediated by factors such as forced or arranged marriage.

Continuing to focus on Muslim women and domestic violence, also pertinent to Muslim women of the UK is the research of Syeda Kanwal Aslam, Sidra Zaheer, Kashif Shafique. Their (2015) study on "Vertically Transmitted" domestic violence through victims identified the continuation of spousal violence in the lives of women in Pakistan, and its transmission as a 'learned behavior' from mothers to daughters.

Forced marriage statistics for 2017 indicate that 1196 new cases were known to and engaged with by the Home Office in 2017. Here again, though not all of these relate to Muslim women, over 60% of cases relate to countries with over 90% Muslim populations. These figures, however, relate only to those that come to the attention of the Home Office and do not provide any information on the psychological impact of forced marriage on the individual or the family. The prevalence of forced marriage in Muslim communities is not known. The psychological implications are currently only evident through casework.

With regards to research that focuses on Muslim children and young people, there is a lack of UK data specifically on mental health. Some lessons can be learned from the data that exists concerning ethnicity. The 2014 report by the Afiya Trust highlights how specialist child and adolescent mental health services (CAMHs), as well as the various programmes and initiatives aimed at prevention and early intervention, are falling short concerning the provision of services to BME children and young people. This is significant regarding Muslim communities as approximately a third of all Muslims in the UK are under 16 years old.

The coalition government's 2011 publication No Health without mental health, indicated that 10% of children and young people between 5 and 16 years old are believed to have a mental health problem. Though figures are available for mental health disorders for adults regarding ethnicity, none appear available for BME children and young people or specifically for Muslims considering the disproportionate weighting of Muslim communities towards the under 16s. Also, identified risk factors for children and young people regarding mental health rarely include Islamophobia, racism or racial harassment.

There is a correlation between relative deprivation and mental illness (World Health Organization and Calouste Gulbenkian Foundation 2014). In this context; 3 out of 4 Bangladeshi Children aged 7 living in England were found to be living in deprivation. Pakistani and Bangladeshi families were over 3 times more likely than White British people to live in the most deprived 10% of neighbourhoods in England[66] (The Millennium Cohort Study Initial Findings 2014) (GOV.UK Ethnicity facts and Figures 2018). This is further complicated by the overall poor assessment and treatment of Black and minority ethnic parents and children's mental health problems, and the ongoing effect in this context that poor parental mental health can have the wellbeing of BME children (Green, Pugh & Roberts 2008).

The above information forms the context for the concerns relating to the mental health of Muslim children and young people that remain unaddressed. Concerns such as:

- Anxiety in third generation Muslim young people who through their interactions across communities must form multiple or hybrid identities to interact effectively across cultures.

- Mismatch or discontinuity of values and practices between the school and home environment placing psychological strains on Muslim children and young people specifically girls over and above those experienced by white counterparts causing tension and anxiety.

- In this mismatch of values, the misinterpretation of Muslim values where, for example, respectfulness is seen as submissiveness and modesty construed as traditionalism,

[66] Over 90% of people in Bangladesh and Pakistan are Muslim.

leading to a minority of Muslim girls and young people not learning to cope with this but instead suffering from psychosomatic illnesses depression or anxiety.

- Institutional neglect impacting young people particularly men in emergent Muslim communities and established communities in areas of relative poverty where apparent social problems including poor educational performance and street crime *may* be related to psychological problems such as ADHD. (ADHD is a psychological problem which may develop from emotional trauma, presenting in such experiences as being an unaccompanied minor asylum seeker, wider issues of migration and forced migration or poverty.)

- Difficulties experienced by young women regarding relationships and or abuse and the related emotional distress and suffering of the individual as it is valued relative to the honour of the family.

Muslim men remain a difficult group to identify in mental health research data beyond current concerns regarding radicalization, which in reality, relate to very small numbers of Muslim men. It is concerning that there is a lack of research on the mental health of half the community.

Muslim communities as a whole do however experience Islamophobia. Though much has been noted in crime figures including spikes in anti-Muslim hate crime in the wake of terrorist incidents, the anxiety this creates in Muslim communities is generally not addressed in mental health work. Data on the effect of Islamophobia on Muslim mental health is absent in the UK and relatively scarce elsewhere. M Amer in her 2012 study of anxiety and depression in post-September 11 Arabs in the US found a quarter of participants reported moderate to severe anxiety levels as measured by the Beck Anxiety Inventory (BAI), while half of the sample reported depression scores that met clinical caseness as assessed by the Center for Epidemiologic Studies-Depression Scale (CES-D). The sample of Arab Americans reported significantly higher levels of anxiety and depression compared to standardization samples and community samples of four other minority groups. Kunst Sam and Ulleberg in their 2013 publication on the development and validation of the perceived Islamophobia scale (PIS) note the lack of research on the psychological impact of Islamophobia on Muslims. In the development and testing of the PIS, they worked with samples of Muslims from Germany, France and the United Kingdom to validate their study. They found that perceptions of Islamophobia in two samples negatively predicted psychological distress after controlling for experiences of discrimination, suggesting the insufficient impact of anti-discrimination laws in protecting Muslim minorities from the negative effects of stigma on psychological wellbeing.

Islamophobia is a form of stigma. Though the psychological research on the effects of Islamophobia is limited, there is data on the impact of stigma on health. This includes the 2015 O'Donnell, Corrigan, Gallagher study, which found that there was an impact to both psychological and physical health in the context of actual and anticipated stigma. This brings us to the interactions between mental health and physical health particularly experienced in Muslim communities.

A substantial number of people with long term conditions such as cardiovascular disease (CVD) or diabetes also experience poor mental health which may lead to poorer health outcomes and reduce life expectancy. Relative costs to health care are also significant as co-morbid mental health problems exacerbate physical illness and complicate its treatment. In the absence of faith-related health data with regards to long term conditions, there are specific health inequalities experienced by ethnic minority communities that make up the bulk of Muslim communities in the UK. In general, South Asian groups showed higher rates of CVD, with Pakistani and Bangladeshi groups higher than Indian groups. South Asian men are 50% more likely to have coronary heart disease than men in the general population. Bangladeshis have the highest rates (followed by Pakistanis, then Indians and other South Asians). With regards to diabetes, the 1999 and 2004 Health Surveys of England both reported that the observed prevalence was markedly higher in Bangladeshi and Pakistani patients. For the Bangladeshi and Pakistani population, this represents an almost five times higher prevalence than the general population (Lowth M, Jackson C 2015).

Contributory factors to this may include the combined effects of:

- genetic variation,
- socio-economic differences (affecting poverty, nutrition and housing conditions), and *differences in social and cultural beliefs and lifestyle practices* (e.g. differences in diet/food habits, in taking exercise, and in treatment-seeking behaviour).

But with a lack of information on common mental health problems within Muslim communities, and with faith unrecognised as a possible factor, there is a lack of clarity as to the impact of:

a) Mental distress, common mental illnesses on physical health treatment non-compliance and religious fatalism.
b) Faith as a defining factor concerning cultural beliefs, 'lifestyle practices' or emotional resilience.
c) The extent, and nature of mental and physical ill-health co-morbidity, in Muslim communities and,
d) The role that *beliefs* may play (positive or negative) concerning such co-morbidity and or related treatments.

Considering the significance of faith regarding Muslim mental health and the above data including the evaluation it can be said that:

- Contributory factors to Muslim mental health inequalities include both the quality and form of statutory mental health provision and the experiences of being Muslim living in the UK at this time;
- there is the lack of UK data on Muslim mental health, and sufficient indications from wider research that UK common mental health problems in Muslim communities are

often linked to multiple or complex unaddressed social causes and are as such also complex,

- this raises specific concerns regarding co-morbidity between mental health problems and long-term conditions or medically unexplained symptoms in respect to their assessment and treatment in Muslim communities in line with Mir's findings in 2005 and 2010.

Conclusion

This chapter has explored the interaction between Muslim beliefs derived from faith in Islam and the interpretation of experience regarding wellbeing. It has also considered data on faith and spirituality and its impact on wellbeing and data on Muslim mental health and wellbeing. It has indicated ways in which mental health provision in the UK, in general, does not address the relationship between mental health and faith within Muslim communities.

The chapter has shown that current therapeutic models miss core aspects of identity within this faith community impacting on mental health assessment and treatment. In this context, it has presented evidence from a long term evaluation of the efficacy of an alternative approach to Muslim mental health, Islamic counselling a faith-based therapeutic intervention practised with NHS patients with complex presentations of mental and long term physical health problems. The research has shown an 82% reduction in patient use of secondary care.

Data presented here shows evidence of the efficacy of Islamic counselling in the treatment of common mental health problems in complex presentations. This is not a typical initial efficacy trial but is responsive to the expressed need identified in the context of agencies on the ground and the lack of alternative appropriate provision. Further research is required on this model of Islamic counselling to verify both its efficacy and its effectiveness as a psychotherapeutic modality. Such research could be part of a strategic response to addressing Muslim mental health inequalities in the present context.

The chapter has presented available research relevant to understanding the complex nature of Muslim mental and physical health. This indicates that though faith is significant in Muslim understandings of personal experience, but Muslim wellbeing is also impacted by factors such as relative deprivation, refugee status, histories of physical psychological or domestic violence often within wider geopolitical contexts. Such socio-economic and geo-political factors *may* relate more to the causation of Muslim mental ill-health than 'culture'; but, these are experienced in the context of a faith identity.

This chapter including the evaluation of Islamic counselling has argued that faith is a significant factor in the mental wellbeing of Muslims in the UK but a factor that presently receives less consideration than it warrants. Muslims often have difficult complex life experiences impacted by factors such as Islamophobia and racism that negatively impact on mental wellbeing. However common UK therapeutic practice appears ill-equipped to address the realities of contemporary Muslim life. But such experiences can be held in a therapeutic relationship that

enables the client to come to an authentic understanding and reappraisal of their experience in the context of what they believe and know to be true. Islamic counselling provides such a therapeutic space.

Stephen Abdullah Maynard and his colleague Sabnum Dharamsi have provided training in Islamic counselling since 1998
www.islamiccounselling.info
Stephen Abdullah Maynard is also the chairperson of the Lateef Project

www.lateefproject.org

References

1. Altalib, H., Elzamzamy, K., Fattah, M., Ali S., & Awaad, R., 2019. Mapping global Muslim mental health research: analysis of trends in the English literature from 2000 to 2015. Global Mental Health (2019), 6(6), 1-10

2. Amer, M., & Hovey, J., 2011. Anxiety and depression in post September 11 Arabs in the USA Social Psychiatry 47(3):409-18 · February 2011

3. Amer, M.M., & Hovey, J.D. 2012. Anxiety and depression in a post-September 11 sample of Arabs in the USA. Social Psychiatry and *Psychiatric Epidemiology*, 47 (3), 409-418.

4. An Nawawi 40 Hadith https://abuaminaelias.com/forty-hadith-nawawi/

5. APA 2013. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition is the 2013 update to the Diagnostic and Statistical Manual of Mental Disorders, the taxonomic and diagnostic tool published by the American Psychiatric Association in the United States of America.

6. BBC 2018. Religious hate crimes: Rise in offences recorded by police https://www.bbc.co.uk/news/uk-45874265

7. Baron, N., 2002. Community based psychosocial and mental health services for southern Sudanese refugees in long-term exile in Africa. In J.T.V.M. de Jong (Ed.), *Trauma, war, and violence: Public mental health in a socio-cultural context.* New York: Kluwer.

8. Belaire, C., & Young, J., 2000. Influences of spirituality on counsellor selection. Counseling and Values, 44(3), 189-197.

9. Bhugra, B., 2002. Suicidal Behaviour in South Asian in the UK. Crisis the Journal of Crisis Intervention and Suicide Prevention 23(3): 108-13

10. Bhui, K., Bhugra, D., Goldberg, D., Dunn, G. and M. Desai 2001. "Cultural influences on the prevalence of common mental disorder, general practitioners' assessments and help-seeking among Punjabi and English people visiting their general practitioner" Psychological Medicine31(5): 815-825

11. Considine, C., (2018). Islam, Race and Pluralism in the Pakistani Diaspora (Studies in Migration and Diaspora). Routledge ISBN-10: 1138207225.

12. Cornah, D., 2006. The Impact of spirituality on mental health. A review of the Literature Mental Health Foundation. ISBN: 978-1-903645-85-7.

13. Davidson, G., Murray, K., & Schweitzer, R., 2008. Review of refugee mental health and wellbeing: Australian perspectives. Australian Psychologist 43(3), 160-174.

14. De Lusignan, S., Jones, S., McCrae, N., Cookson, G., Correa, A., & Chan, T., 2014. IAPT LTC/MUS Pathfinder Evaluation Project Phase 1 Final report. University of Surrey https://www.uea.ac.uk/documents/246046/11991919/LTCMUS-pathfinder-evaluation--phase-1.pdf/842c7eb3-9d97-4a24-9ad4-f86aac50ecf4

15. Department of Human Services 2008. Refugee health and well-being action plan: 2008-2010. Social Policy Branch, Victorian Government Department of Human Services: Melbourne.

16. The Department of Health No health without mental health: Cross Government Mental Health Strategy for People of All Ages (2012) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

17. Department of Health and Social Care 2011. No Health without Mental Health: Implementation Framework https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216870/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf

18. Department of Health 2018. Service Framework for Mental Health and Wellbeing 2018-2021. https://www.health-ni.gov.uk/sites/default/files/consultations/health/MHSF%20-%20Service%20Framework%20-%202018-2021.PDF

19. Dharamsi, S., & Maynard, A., Islamic Based Interventions in Counselling Muslims a Handbook of mental health issues and interventions Ed Ahmed, S., Amer, M., Routledge New York 2012.

20. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) by American Psychiatric Association (2013)

21. Esposito, J., 2014. The Oxford Dictionary of Islam. Oxford: Oxford University Press. http://www.oxfordislamicstudies.com/article/opr/t125/e541

22. Fazel, M., Wheeler, J., & Danesh, J., 2005. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. The Lancet 365(9467): 1309-14.

23. Fazil, Q., Wallace, L., Singh, G., Ali, Z., and Bywaters, P., 2004. 'Empowerment and advocacy: reflections on action research with Bangladeshi and Pakistani families who have children with severe disabilities', Health and Social Care in the Community, 12, 5, pp. 389–97.

24. Fink P., 1992. Surgery and medical treatment in persistent somatizing patients. *Journal of Psychosomatic Research*. **36** 439–47

25. Frager, R., 1999. Heart, Self, Soul: A Sufi Approach to Growth Balance and Harmony. Quest Books. ISBN-10: 083560778X

26. Gerritsen, A., Bramsen, I., Deville, W., van Willgen, L., Hoven, J., & van der Ploeg, H., 2006. Physical and Mental health of Afghan, Iranian and Somali asylum seekers and refugees living in the Netherlands. Soc Psychiatr Epidemiol 41(1): 18-26

27. Gillam, S., Jarman, B., & White, P. L., 1989. Ethnic differences in consultation rates in urban general practice. British Medical Journal, 229, 953-957.

28. GOV.UK 2018. Ethnicity Facts and Figures. https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/demographics/people-living-in-deprived-neighbourhoods/latest

29. Guinee, J., P., & Tracey, T. J. G., 1997. Effects of religiosity and problem type counsellor description ratings. Journal of Counselling and Development, 76, 65-73.

30. Gupta, J., Falb, K., Carliner, H., Hossain, M., Kpebo, D., Annan, J., 2014. Associations between Exposure to Intimate Partner Violence, Armed Conflict and probable PTSD among women in Rural Cote d'Ivoire. PLOS|ONE https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0096300

31. Greene, R., Pugh, R., & Roberts, D., 2008. SCIE Research Briefing 29 Black and minority ethnic parents with mental health problems and their children https://www.scie.org.uk/publications/briefings/briefing29/

32. Health-Kelly, C., Strausz, E., 2018. Counter Terrorism in the NHS; Evaluating Prevent Duty Safeguarding in the NHS. Warwick University https://warwick.ac.uk/fac/soc/pais/research/researchcentres/irs/counterterrorisminthenhs/project_report_60pp.pdf

33. Home Office 2018. Forced Marriage Unit Statistics 2017. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/730155/2017_FMU_statistics_FINAL.pdf

34. Kanwal Aslam, S., Zaheer, S., Shafique, K., 2015. Is Spousal Violence Being 'Vertically Transmitted' through Victims? Findings from the Pakistan Demographic and Health Survey 2112-13. PLOS|ONE https://journals.plos.org/plosone/article/authors?id=10.1371/journal.pone.0129790

35. Kelly, E. W., Jr. 1995. Spirituality and religion in counselling education: A national survey. Counsellor Education and Supervision, 33, 227-237

36. Kim-Prieto & Diener, 2009. Religion as a source of variation in the experience of positive and negative emotions The Journal of Positive Psychology 4(6):447-460 · November 2009

37. Kulkens, M., 2009. Access to specialist services by refugees in Victoria Victorian Refugee Health Network. http://refugeehealthnetwork.org.au/wp-content/uploads/Specialist_access_reportNov301.pdf

38. Kunst, J. R., Sam, D. L., & Ulleberg, P. 2013. Perceived islamophobia: Scale development and validation. *International Journal of Intercultural Relations, 37*(2), 225-237.

39. Lowth. M., Jackson. C., 2015. Diseases in Different Ethnic Groups. https://patient.info/doctor/diseases-and-different-ethnic-groups

40. Malek, M., 2011. Enjoy Achieve and Be Healthy. The Mental Health of Black and minority ethnic children and young people. The Afiya Trust https://stbasils.org.uk/files/2014-07-30/Enjoy-achieve-and-be-healthy.pdf

41. Maynard. A., 1998 Beginning at the Beginning Islamic counselling Race & Cultural Education in Counselling RACE Multi-Cultural Journal Inter Cultural Healing & Spirituality No 16 Summer 1998

42. Maynard, S., 2007. Muslim Mental Health: A Scoping Paper on theoretical models, practice and related concerns in Muslim Communities. https://www.scribd.com/document/90324305/Muslim-Mental-Health-Stephen-Maynard

43. Mental Health Vulnerable Groups and Offenders Branch Welsh Government 2019. Together for Mental Health Delivery Plan 2019-2022. Welsh Government July 2019. https://gov.wales/sites/default/files/consultations/2019-07/together-for-mental-health-delivery-plan-consultation-document.pdf

44. Mir, G., 2005. The Impact of Faith Identity on the Healthcare and Health of Pakistani Muslims. The Future of Multicultural Britain University of Roehampton

45. Mir, G., Sheikh, A., 2010. 'Fasting and Prayer don't concern doctors…they don't know what it is': communication, decision-making and perceived social relations of Pakistani Muslim patients with long term illnesses. Ethnic Health 2010 Aug;15(4):327-42. doi: 10.1080/13557851003624273

46. Morrison, J., Clutter, S., Pritchett, E., & Demmitt, A., 2009. Perceptions of clients and counseling professionals regarding spirituality in counseling. Counseling and Values, 53(3), 183

47. Naylor J., *et al*. 2012. Long-term conditions and mental health. The cost of co-morbidities. London. The Kings Fund.

48. NICE 2018. Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups Quality Standard Published: 11 May 2018 https://www.nice.org.uk/guidance/qs167/resources/promoting-health-and-preventing-premature-mortality-in-black-asian-and-other-minority-ethnic-groups-pdf-75545605479877

49. NICE 2018. Depression in adults: treatment and management a Clinical guideline Draft for consultation July 2017 not in circulation

50. NICE 2005. Depression in children and young people: identification and management (CG28) Published 26 September 2005 https://www.nice.org.uk/guidance/cg28/resources/depression-in-children-and-young-people-identification-and-management-pdf-975332810437

51. NHS England 2016. The Five Year Forward View for Mental Health Published February 2016 NHS England https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

52. Odell, S. M., Surtees, P. G., Wainwright, N. W. J. *et al* 1997. Determinants of general practitioner recognition of psychological problems in a multi-ethnic inner city health district. British Journal of Psychiatry, 171, 537–541.

53. O'Donell, A.T., Corrigan, F., Gallagher, S., 2015. The impact of anticipated stigma on psychological and physical health problems in the under employed group. Front Psychol. 2015; 6: 1263. NCBI https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4548078/

54. Office for National Statisticshttp://www.ons.gov.uk2011 tableshttp://www.ons.gov.uk/ons/guide-method/census/2011/index.html2001 tableshttp://www.ons.gov.uk/ons/guide-method/census/2011/census-data/2001-census-data/2001-census-da-ta-tables/index.html

55. Oyserman, D., & Lee, S. W. S. (2008). Does culture influence what and how we think?: Effects of priming individualism and collectivism. Psychological Bulletin, 134,311–342.

56. Platt, L., Smith, K., Parsons, S., Connelly, R., Joshi, H., Rosenberg, R., Hansen, K., Brown, M., Sullivan, A., Chatzitheochari, S., Mostafa, T., 2014. Millennium Cohort Study Initial findings from Age 11 survey. Centre for Longitudinal Studies, The Institute of Education University of London

57. Quackenbos, S., Privette, G., & Kelntz, B., 1985. Psychotherapy Sacred or secular? Journal of Counselling and Development, 63, 290-293.

58. Reid, S., Wessely, S., Crayford, T., & Matthew Hotopf. 2001. Medically unexplained symptoms in frequent attenders of secondary health care: *retrospective cohort study BMJ 2001; 322 doi: https://doi.org/10.1136/bmj.322.7289.767*

59. Reid S., *et al.* 2002. Frequent attenders with medically unexplained symptoms: service use and costs in secondary care. *British Journal of Psychiatry*.**180** 248-53

60. Rose, E., Westefield, J., & Ansley, T., 2001. Spiritual issues in counselling: Client's beliefs and preferences. Journal of Counselling Psychology, 48(1), 61.

61. Scottish Government Population Health Directorate (2017). Mental Health Strategy 2017-2027. Scottish Government gov.scot March 2017. https://www.gov.scot/publications/mental-health-strategy-2017-2027/

62. Simon, 2005 – Simon GE, Von Korff M., Somatization and psychiatric disorder in the NIMH Epidemiologic Catchment Area study. *American Journal of Psychiatry* 1991 **148** 1494–500

63. Simon, G.E., VonKorff. M., 2005. Lin E. Clinical and functional outcomes of depression treatment in patients with and without chronic medical illness. Psychol Med; 35: 271-279.

64. Simon, G. E., & Von Korff, M., 1991. Somatization and psychiatric disorder in the NIMH Epidemiologic Catchment Area Study American Journal of Psychiatry 148(11): 1494-500 https://www.ncbi.nlm.nih.gov/pubmed/1928462

65. UNHCR 2017. Global Trends forced displacement in 2017 https://www.unhcr.org/globaltrends2017/

66. Vijayakumar, L., & Jotheeswaran., A. T., 2010. Suicide in refugees and asylum seekers. Mental Health of Refugees and Asylum Seekers pp 195-210. Edited by Bhurgra, Craig, & Bhui, Oxford University Press ISBN -13 9780199557226

67. World Health Organization and Calouste Gulbenkian Foundation, 2014. Social determinants of mental health. Geneva, World Health Organization.

68. Ysseldyk, Matheson & Anisman, 2010. Religiosity as identity: toward an understanding of religion from a social identity perspective. Pers Soc Psychol Rev. 2010 Feb;14(1):60-71.