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Mental health services for Muslim communities in England and Wales: developing a more collaborative model

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ABSTRACT

The landscape of mental health services for Muslim communities in England and Wales remains fragmented with many Muslims unsure how to access services that accommodate their religious beliefs and practices. This article reports findings from a pilot study of mental health services and Muslim communities in England and Wales. It explores the role of Muslim mental health organisations, charities, therapists, counsellors, faith leaders and community groups in supporting the communities they serve. The study's aim was to establish a larger project to identify and amplify best practice across mainstream and non-mainstream mental health services in relation to improving provision for Muslim communities. Focus group data from key informants was analysed using grounded theory. Four analytical themes emerged from the analysis: "Knowledge gaps", "Policy gaps", "Working together" and "Moving forward". Based on this, the authors argue for an asset-based approach to building collaborative partnerships between Muslim communities and mental health providers.

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Mental health; Muslim communities; collaboration model; best practice; England and Wales

Introduction

This article reports findings from a pilot study designed to gather the knowledge required to conduct a larger study on mental health services for Muslim communities in England and Wales – the *Faith in Mental Health* research project. Findings suggest the need and potential for an asset-based, collaborative approach to mental health services to accommodate religious and cultural needs within Muslim communities.

The article opens with a review of academic literature concerning religion and mental health including remarks on mental health services in Britain, jinn possession and previous research on mental health and Muslim communities. A short section describing the research methods employed during the pilot study is followed by the study's findings. Four key analytical themes are discussed: "Knowledge gaps", "Policy gaps", "Working together" and "Moving forward". Insights from a focus group of key informants including faith

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leaders, academics, chaplains, policy advisors, psychotherapists and community organisations provides analytical context. The discussion first turns to previous scholarship.

Academic literature concerning religion and mental health

Many people use religion to cope with life events (Allport, 1950; Freud, 1933; Koenig, 2018; Rosmarin & Koenig, 2020). Researchers studying the impacts of religious coping have observed both positive and negative mental health outcomes (Aksoy et al., 2022; Pargament & Abu-Raiya, 2007; Pargament & Brant, 1998). The effects of religious belief and practice on emotional wellbeing are also discussed in the Islamic tradition. Early Muslim scholars agreed that connections between the mind, body and spirit are crucial for emotional health (El Azayem & Hedayat-Diba, 1994; Haque, 2004). These ideas have provided a foundation for the development of contemporary Islamic psychology reintroducing holistic wellness from Islamic perspectives (Awaad et al., 2020; Badri, 2018; Haque et al., 2016; Rothman & Coyle, 2020).

Though early Islamic scholarship asserted mental and emotional health, more recent research suggests a range of outcomes in Muslim communities and other faith groups. In particular, the internal factors (Ali et al., 2022; Cinnirella & Loewenthal, 1999; Ibrahim & Whitley, 2021) and external forces (Loewenthal, 2012; Pirutinsky et al., 2009) that affect people's approaches to mental health services.

Mental health services in Britain

The history of mental health services in Britain since 1945 has two main narratives: the increased use of pharmaceutical drugs and the decreased use of nineteenth century-style incarceration (Turner et al., 2015). Policy and legislative milestones include: the Mental Health Act 1983 (which provides much of the current legal framework for the detention of patients); the introduction of NHS Trusts and independent Mental Health Trusts from 1991 to 1996; the first policy statement on integrated mental health services in 2006; and the Mental Health Act 2007 (2015, p. 603).

More recent developments include the introduction of NHS England's *Improving Access to Psychological Therapies* programme in 2008, now known as *NHS Talking Therapies* (Baker & Kirk-Wade, 2023). The NHS model of talking therapies treats anxiety, depression and other mental illnesses using three main approaches: guided self-help; counselling; and cognitive behavioural therapy (CBT). According to the NHS, CBT is based on the concept that "thoughts, feelings, physical sensations and actions are interconnected, and that negative thoughts and feelings can trap you in a negative cycle" (NHS, 2023).

There is an expansive range of private counselling and therapy services alongside publicly funded mental health services. There are also numerous community and voluntary organisations offering mental health support. Whilst it is difficult to quantify the size of the market, two clues as to its recent growth are the long queue for treatment from the NHS and increased demand for personal development therapy (Anonymous [The Economist] 2023). Research suggests that 1.5 million seek support from 16,000 qualified counsellors listed on a UK database of private providers (Greedus, 2020).

The emerging concept of "Islamic psychology" (Rothman, 2022) represents a third, smaller model. Islamic psychology reconstructs psychology within an Islamic paradigm with emphasis on a "uniquely Islamic ontological understanding of the human being and a framework for practical applications of such a model in psychotherapy" (2022,

p. 171). In Islamic psychology, the self is centralised in the heart and eternal soul rather than the mind as per Western conceptions of human psychology.

Sitting between “Western” models such as CBT and Islamic psychology are models of mental health which represent attempts to make mental health treatment and support more inclusive for Muslim people. These include: wellbeing programmes organised by grassroots community organisations (The Lantern Initiative, 2021); networks of private Muslim practitioners (Muslim Counsellor and Psychotherapist Network, 2023); and attempts to reconfigure CBT for Muslim patients (Munawar et al., 2023).

Jinn possession

The ways that communities define and think about mental health impacts upon help-seeking practices. For example, stigmatising mental health experiences can lead to a fear of exclusion from a religious community or being perceived as lacking faith (Aloud & Rathur, 2009; Baruch et al., 2014; Ibrahim & Whitley, 2021).

Another example is the belief that jinn possession causes mental ill health symptoms. Littlewood (2004) describes possession as a supernatural entity entering a human being controlling their actions and causing altered states of consciousness. As Ibrahim and Whitley (2021) explain, jinn are supernatural beings that live alongside humans whilst invisible to them. They are described in the Qur’an and hadith as exercising free will and possessing powers. Although jinn are widely accepted among Muslims, the extent to which they can interact with humans is contested. Opinions differ as to whether they can possess humans physically.

Jinn possession and other supernatural phenomena are often cited as negative factors when discussing Muslims’ use of mainstream mental health services (Ibrahim & Whitley, 2021). On this basis, some argue that it is necessary to understand the cultural context of jinn belief when diagnosing Muslims subscribing to this view (Keshavarzi & Haque, 2013).

Research has established that jinn possession is still relevant among Muslim groups in the UK. Dein et al. (2019) found that belief in jinn as causes of misfortune is common among older Bangladeshi Muslims in East London. However, Knifton (2012) found that traditional beliefs about jinn possession were less common among younger Muslims in Scotland suggesting the intergenerational differences in the understanding of mental health within Muslim communities. Although most respondents in Khalifa and Hardie’s (2005) study believed jinns to be real, fewer accepted that they cause harm. Around half stated that symptoms should be treated by both doctors and religious leaders. Arguably, when defining mental health through religious concepts, religiously informed treatment is required to comply with patients’ worldviews.

Despite this, patients have reported being reduced to their symptoms and their beliefs being dismissed as irrelevant or unhelpful (Baker, 2010; Koenig, 2018). Therefore, some faith believers, particularly from Muslim and Orthodox Jewish communities, are hesitant to engage with NHS mental health services, fearing that their beliefs will be misunderstood or viewed as pathological (Dein et al., 2019; Loewenthal, 2012). Overall, there are disconnections between faith communities and NHS mental health services (Baker, 2010).

Previous research on mental health services and Muslim communities

Research on mental health services and Muslim communities suggests wider contexts: public health; minority communities in Western societies; the role of religion in shaping

understandings of mental health, and institutional forms of Islamophobia. The current research question suggests one such context is the broader understanding of “mental health” within Muslim communities as a discursive concept gathering ideas related to emotional, psychological and social wellbeing. However, given the size of the Muslim population of England and Wales – 3.9 million (ONS, 2023) – and its ethnic, social and cultural diversity, ascribing a universal understanding of “mental health” to such a diverse social group is neither realistic nor desirable. Doing so risks reinforcing the same reductive processes that drive the prejudices Muslims often face when engaging with public bodies. However, strong clues as to a range of attitudes and experiences within Muslim communities are provided when academic research (Ibrahim & Whitley, 2021) is cross-referenced with community reports that have shaped our understanding of how various notions of mental health are constructed and circulated (Hekmoun, 2019; Inspired Minds, 2020; The Lantern Initiative, 2021; Ramadan Tent Project, 2020; Bunglawala et al., 2021). Relevant themes include: the varied relationships between religiously inspired activities and mainstream mental health services; heterogeneous forms of belief in the role of supernatural forces – such as jinn – and their effect on the material world and mental health; and the integration of aspects of religious belief and practice into clinical and therapeutic settings (Ibrahim & Whitley, 2021, pp. 171–172).

Community-based research reveals many Muslims view mental health as being as important as physical health (The Lantern Initiative, 2021). This implies a widespread acceptance of the concepts of mental health (Ramadan Tent Project, 2020). Issues commonly understood as ill health range from anxiety and identity struggles, through to depression and suicidal thoughts (Hekmoun, 2019). Islamic belief and mainstream mental health services are not often seen as entirely incompatible although there is strong evidence for widespread preferences for culturally sensitive, religiously literate mainstream services and a reluctance to seek mental health support for fear of insensitivity or discrimination (Inspired Minds, 2020; The Lantern Initiative, 2021; Bunglawala et al., 2021). However, mixed levels of reported engagement with counselling services reflect divergent views and experiences within Muslim communities (The Lantern Initiative, 2021; Bunglawala et al., 2021). For example, a variety of cultural attitudes may determine reactions to mental health issues (The Lantern Initiative, 2021, p. 20) and faith-based counselling which is viewed positively and negatively (2021, p. 24).

These reports imply a strong sense of agency among Muslim organisations: public health issues and community concerns being addressed directly by Muslim-led organisations. Their publication reflects a pro-active approach to raising awareness and implies hope that access to mental health services in Muslim communities will increase over time. Moreover, they suggest the need to further build and improve partnerships between Muslim communities, mental health organisations, and NHS and private mental health services. As such, this study aims to ascertain how these partnerships can be established and maintained to offer more suitable services for Muslim communities.

Methods

A focus group of expert key informants was convened and a semi-structured discussion facilitated to explore Muslim communities and mental health. Researchers used generic

purposive sampling (Bryman, 2012, p. 422) to recruit key informants on mental health provision and faith including academics, faith leaders, chaplains, policy advisors, psychotherapists, and representatives of community organisations. Thirteen participants attended, both online and in-person. Respondents from Christian and Jewish backgrounds were invited to acknowledge that lack of access to faith-sensitive provision is a common problem and not merely a “Muslim issue” Table 1.

Broad questions were posed ahead of the session to steer discussion addressing the study’s research questions. Focus group questions focused on how faith communities and mental health practitioners might be supported to offer more religiously sensitive services and increase access to care.¹ The session was chaired by one of the authors although with a light touch to encourage interaction between participants. The session followed a loose structure of introduction, context, discussion, and reflections.

The authors used Zoom to record and transcribe the discussion. Constructivist grounded theory was used to organise and analyse data. Formulated by Glaser and Strauss (1966), grounded theory is an inductive approach that allows for emerging theory to inform each stage of the research process. Using grounded theory allowed for closer examination of participants’ responses. Charmaz (2006) further developed grounded theory in a more constructivist direction by rejecting Glaser and Strauss’ notion of neutrality, arguing instead that researchers are inevitably part of what is studied.

Grounded theory involves producing codes from collected data which are often categorised into clusters. The researchers of this study adopted Charmaz’s use of gerundives to code actions, in this case experiences and attitudes, rather than isolated topics. These codes were subsequently grouped into categories and sub-categories. These were used to produce emergent findings.

Measuring reliability and validity in qualitative research is difficult due to the uncontrolled nature of social settings (Bryman, 2012). One way to address this is to adopt Guba and Lincoln’s (1994) concepts of trustworthiness and authenticity – satisfied here with reliance on community experts. Based on Yardley’s (2000) criteria of quality for qualitative research, the present study has validity because of its acknowledgement of the social setting in which it was conducted and its intended impact on the community it sought to study.

Table 1. Respondents by gender, occupation, religious background and location within England and Wales.

Respondent	Gender	Occupation	Religious background	Location
1	Female	Academic	Unknown	England
2	Male	Trainee Psychologist	Muslim	England
3	Female	Charity sector	Muslim	England
4	Female	Counsellor	Muslim	England
5	Male	GP	Muslim	Wales
6	Female	Mosque Trustee	Muslim	England
7	Male	Policy Consultant	Muslim	England
8	Male	Imam and Chaplain	Muslim	England
9	Male	Academic	Muslim	England
10	Male	Rabbi and Psychotherapist	Jewish	England
11	Male	Reverend and Chaplain	Christian	England
12	Female	PhD Researcher	Muslim	Wales
13	Female	Psychotherapist	Christian	England

Findings

Four key themes emerged from the analysis: “Knowledge gaps” and “Policy gaps” represent the more negative aspects of respondents’ attitudes; “Working together” and “Moving forward” represent more positive aspects.

No claim is made as to the exhaustive nature of this pilot study. Focus group participants discussed other topics and the main study will undoubtedly yield many more. Themes overlapped during an open and free-ranging discussion and the codes used here should not be regarded as mutually exclusive. Instead, they represent an initial attempt to organise expertise on mental health and faith groups with a specific focus on Muslim communities in England and Wales.

Context

Respondents provided the context for the analytical themes. An academic researcher (Respondent 9) described increased mental health awareness throughout society and the inevitable increase within Muslim communities:

It’s something that’s been taken seriously recently; I don’t think Muslims are particularly exceptional at all.

A counsellor (Respondent 4) offered insight into the general shift within therapeutic professions: “We’re definitely moving in the direction of working with clients holistically”.

Respondents acknowledged the improved relationship between psychology and religion. A religious leader and psychotherapist (Respondent 10) described how psychology has “moved on hugely and many therapists can now see the value of religion in bringing about health”. Respondent 4 agreed, stating: “The gap between the two has definitely narrowed”.

Positive sentiment, however, should not be overstated and was balanced by concerns regarding religious literacy within mainstream provision. An NHS trust chaplain (Respondent 11) explained:

Most of our clinicians don’t have any lived or academic experience of theological frameworks or religious worldviews ... often religion and spirituality are undervalued.

Other respondents argued that researchers in the field should consider the complex structure of mental health, ill health and treatment. Respondent 1, a researcher, explained:

You have two spectrums or domains, one for mental health – lower and higher functioning, and one for mental illness – lower and higher functioning.

Respondent 4 described a diverse spectrum of individuals and groups – from chaplains to charities – working within mental health:

At one end we have practitioners doing direct clinical work, to the other end where we’re seeing the prolific pop-up nature of Muslim mental health organisations which are at the awareness end.

Respondents made a distinction between clinical practice and raising awareness of mental health. According to the group, both are necessary but require different approaches. Within this context, the group agreed that conversations about Muslim

mental health must go beyond repetitive discussions of community stigmatising and the barriers to accessing mainstream services. A PhD researcher (Respondent 12) argued for more innovation: “I think there’s a need for more unique research projects”.

Respondents offered an important reminder that Muslims in England and Wales should not be regarded as a homogenous group. Respondents agreed that doing so risks neglecting individual experiences, preventing the development of effective services and undermining holistic approaches. The analysis turns next to the four analytical themes which together describe a complex and fragmented landscape of mental health provision for Muslim communities in England and Wales.

Knowledge gaps

Discussion concerning lack of knowledge on both mental health and religion dominated the conversation. Respondents described mental health knowledge gaps among faith communities and an absence of religious literacy among practitioners. Accordingly, the discussion focused on how information can be communicated more effectively.

A trainee psychotherapist (Respondent 2) shared his experiences in Derby (a small city in the north of England) and the lack of awareness of mental health there:

Something I noticed, specifically in Derby, is a huge lack of understanding of what mental health is, and people’s inability to reach out for help.

Participants alluded to the lack of mental health knowledge among Imams despite their well-meaning intentions to help congregants. Imams were described as sometimes being ill-equipped to deal with mental health issues within their communities. As Respondent 4 said:

There’s a real push, I appreciate, from Imams and [religious] scholars to be counsellors, but they’re not.

A key objective of the main *Faith in Mental Health* project is to help better inform Muslim people seeking mental health support. As Respondent 4 explained:

You [Muslim people seeking help] also need to know about therapy, counselling, what to look for in a therapist or counsellor, the top ten things to ask ...

According to Respondent 6, this should extend to Imams who are well-placed to facilitate such conversations within their communities:

We need to educate our local Imams who are representing our community.

As mentioned, religious literacy among practitioners emerged as a central topic of discussion. Respondent 3 reminded the group of the scale of intervention needed:

Cultural competency and awareness is (sic) needed across the whole workforce.

Respondent 11 highlighted the importance of religious literacy to address issues that may be stemming from a client’s religious belief and practice to ensure that approaches are:

... supporting clinicians to have a generally supportive view of religion, a general sense that there is something valuable in the midst of it but might be manifesting in slightly confusing ways.

All participants recognised the need for more information on mental health and religion. However, several respondents focused on the credibility of sources of information for both Muslim communities and practitioners. As Respondent 5 said succinctly, “the messenger is as important as the message”; implying, perhaps, the effectiveness of more culturally-sensitive communication. Respondent 4 added:

They [informative resources] have to be created by people who know what they’re doing, have been trained in this area.

The need for religious experts to deliver information concerning religious practices was asserted unequivocally by Respondent 9:

If we’re going to bring theology and religious scripture into this, bring in religious experts, theologians, because Islam isn’t a DIY kit.

Policy gaps

Local, regional and national policies were discussed by the group. Participants were particularly concerned that mental health care is underfunded and often regarded as less important than physical health care. A psychotherapist (Respondent 13) said:

We are still struggling to gain equal status of (sic) mental health issues with physical health issues.

The UK Government’s general interactions with Muslim communities were called into question. A policy consultant (Respondents 7) expressed their doubts concerning the efficacy of mental health policy given the Government’s failings in other areas:

How are they [the UK Government] going to handle Muslim mental health issues? As we’ve seen they struggle with Prevent [the UK Government’s controversial counter terrorism strategy] ... How do you get governments to not essentialise Muslims in that way?

Respondent 6, a local mosque trustee, confirmed this:

There are a lot of people that don’t trust other organisations and how they shape policy.

At the subnational level, participants agreed that there are positive examples of NHS trusts (the NHS’ local administrative units) providing good services for Muslim communities. However, policy and practice in this regard is not standardised across England and Wales. For example, NHS Wales has operated via its Health Boards rather than trusts since devolution. Respondent 11 added that “policies would vary on a trust level”. Respondent 3 hoped that that NHS’ new Integrated Care Systems (ICSs) might help standardise local and regional provision:

There’s going to be 42 of these systems [ICSs] that will be decision-making bodies for regions on all things to do with health, and through the legislation there has to be a representative for mental health.

Participants referred to an array of Muslim-led and mainstream mental health charities and initiatives operating at the community level. However, some explained how the lack of available funding for mental health care has restricted their ability to tackle inequalities and barriers to access. A respondent from a mental health inequalities charity (Respondent 3) used children’s mental health to illustrate the consequences:

A lot of organisations are fighting to get children's mental health on the agenda ... so thinking about nuances and inequalities is something that many people are still trying to wrap their heads around.

Working together

Two more positive themes emerged from the analysis. The first, "Working together", gathers expert insights relating to the creation of more synergy between Islamic beliefs and practices and mainstream mental health provision. Respondents again asserted the importance of knowledge exchange and how increased religious literacy among mental health practitioners might improve outcomes for Muslim communities. To accommodate such exchange, respondents agreed that the historical distance between religion and psychology must now be abandoned. Respondent 2 reflected on addressing disconnections between psychological practices and Muslims through Qur'anic evidence:

Something I'm interested in is finding aspects of attachment theory, CBT and humanistic [approaches] within Islamic scriptures such as the Qur'an and hadith and bridging between both of them.

Respondents again emphasised issues of expertise and credibility. Within the context of closer working relations between experts and communities, respondents asserted the need for culturally sensitive knowledge exchange between the creators of information resources and religious experts to better inform community gatekeepers including faith leaders.

Respondent 10 shared how Jewish communities were successfully engaged with Jewish counselling services:

We'd often have conferences, 'Psychology and Religion: Friend or Foe' because Rabbis were hesitant to send their members to a psychiatrist because they didn't trust they would be given proper respect for their religion.

Respondent 6 suggested engaging religious leaders as authoritative voices to inform policymaking on behalf of their communities:

We need to have these conversations with Imams. We need to have scholars and Imams on board to help these policies.

Respondent 5 stressed the importance of working with Muslim-facing organisations:

If we can support these organisations that are trying to coalesce, we're more likely to get this message through because the messengers we're presenting are much more trusted.

Respondents valued working collaboratively with faith communities and representatives to deliver information and mental health care so that they can be received positively by targeted communities. Respondent 1 added simply and unambiguously: "We need to consult with communities". Respondent 12 developed this towards better communication and greater visibility: "We really need things in community languages; we need to be where the people are". Respondent 3 emphasised a community-led, asset-based approach to reform that should "build on the assets that faith communities already have".

Discussion of collaboration between mental health providers and faith communities included the support that could more often be given by chaplaincy teams to health practitioners. Respondent 8, an Imam and chaplain, shared an illuminating short anecdote:

The ward manager made a comment, "I still feel this Muslim patient is mentally unwell, he's still using his hands to eat." So I said, "millions of Muslims have been using their hands to eat and continue to do so."

Respondent 4 developed this further by introducing into the discussion the concepts of *cultural closeness* and *cultural distance* between practitioners and clients. Chaplaincy colleagues are well-placed to offer insight into clients' normative cultural or religious practices. Respondent 8 recommended including chaplains in care teams to promote more holistic approaches to:

... set up trust, where psychologists alongside the chaplaincy team work together. I think this way of thinking with Imam, psychologists and psychiatrists might be more effective.

Moving forward

The fourth and final theme, "Moving forward", gathers discussion topics concerning next steps including several practical recommendations offered by the group. These include resources for clinicians and charities (the spectrum of stakeholders described earlier). Respondents agreed that resources should cover a range of topics from understanding mental ill health and its symptoms to identifying appropriate services and treatments. Respondents again emphasised the importance of having resources that reflect community values and experiences. Respondent 3 revisited earlier themes of mental health and ill health, suggesting a more tailored approach:

People need different information and types of support to move them more towards the healthy side of things.

The group proposed new guidance, a new resource for healthcare practitioners to refer patients to suitable mental health services. Respondent 4 suggested "a credible signposting list of current services". Respondent 5 added:

It would be amazing to be able to refer patients who come from a particular background to a coordinated body of organisations that are competent in that background, have a national base and a breadth of understanding.

Respondent 3 suggested adding expertise into the new ICSs that would "create bespoke briefings for leaders in those systems so that it's on their agenda" and to ensure that any new community-based research has practical utility for the communities concerned.

To support these initiatives, the group offered advice on conducting more responsible policy-related research to improve mental health awareness and better reflect the needs of Muslim communities. Respondent 4 summed up the benefits of more often focusing policy research on the actual needs of communities in which "they're actually linked and when we [researchers and practitioners] work on one, we're working on the other, and the bridge being research".

Two respondents (4 and 12) criticised the reductive nature of previous research for failing to develop an understanding of mental health in Muslim communities beyond

the identification of stigma and barriers. As Respondent 4 said plainly, "... those are two clichés".

Respondent 12 advised that academics who still focus exclusively on stigma and barriers are probably not aware of current priorities within Muslim communities:

While that [stigma and barriers] is important, I think we've moved beyond "Muslims won't go to therapy because there's stigma or taboo".

Discussion

Focus group data analysis revealed a complex, fragmented landscape of mental health provision for Muslim communities in England and Wales with a range of attitudes: from the less positive knowledge and policy gaps clearly visible to the expert group, to its more optimistic accounts of working together and moving forward.

Respondents recommended the use of community-led and asset-based approaches to the provision of mental health services, whether public or private, mainstream or specialist, and the use of better, more sensitively curated information and increased religious literacy to help build bridges between providers and Muslim communities.

Invariably, there are limitations to pilot studies and the present study was no exception. A greater number of participants and focus groups would have resulted in a greater number of codes and would have further strengthened the conclusions presented here. Given this, the authors make no claim as to the representativeness of the sample or the study. Similarly, more Muslim respondents would have allowed us to further explore the rich diversity of the UK's Muslim population. It should also be noted that the focus group does not adequately reflect the Welsh population given that most participants resided in England. For that, a larger sample was required. The key objective in convening the group was to gather the expertise needed to conduct a larger, far more representative study on mental health services and Muslim communities.

Analysis of focus group data confirmed previous research: there are now a range of diverse community-led initiatives filling gaps in public mental health provision. The emergence of independent Muslim mental health practitioners, charities and umbrella organisations suggest that Muslim communities, like other faith groups, use the expertise and resources available to them to fulfil their needs. These organisations have played a crucial role in shedding light on mental health challenges within Muslim communities while, at the same time, involved in signposting or providing mental health services. Various reports by community organisations have urged the NHS to acknowledge and respond to these issues. A report from The Lantern Initiative (2021) recommended co-creating services using the expertise already present in Muslim communities to offer faith and cultural training to health professionals.

Analysis also revealed a shared belief among respondents that conversations around stigma and access barriers have become almost redundant. While previous research cited stigma within Muslim communities as a key factor in their underuse of public services (Aloud & Rathur, 2009; Cifti et al., 2013; Knifton et al., 2010), other research (Dein & Illaiee, 2013) has revealed that stigma is now less common among younger Muslims. The Lantern Initiative (2021) further highlighted the need for research to address other considerations including the impacts of colonial trauma. Mental health services must

consider what is relevant to Muslim communities including the benefits of religious coping mechanisms found within the practice of Islam.

Analysis revealed dissatisfaction with the UK Government's interactions with Muslims. Issues concerning policing and counterterrorism have damaged trust between Muslims and public services with widespread fears of a more securitised public sector (O'Toole et al., 2016). These concerns deter some Muslims from entering public mental health services for fear of being referred to the police if their beliefs, practices or mental states are considered problematic. To address these concerns, mental health services must first acknowledge the positive role that faith can play in fostering and maintaining mental wellbeing. Additionally, information about mental health care must be delivered by those deemed credible by Muslim communities. Given these challenges, public and charity sector bodies, such as the NHS and mainstream charities, must work in partnership with trusted community members and organisations.

This more collaborative approach is exemplified in the aforementioned account of successfully informing a local mosque congregation in Derby about mental health issues and services. Identifying and amplifying best practice such as this is a key objective of the *Faith in Mental Health* project. A further aim is to learn from other faith communities, such as Jewish communities in the UK, who have developed and facilitated faith-sensitive approaches to mental health services that acknowledge uniquely Jewish needs.

Discussion of credibility emphasised that the way mental health information is communicated to minority faith communities is vital to how it is received. Communicating public health messaging in appropriate languages, for example, is highly likely to build or repair trust in public agencies (Di Carlo et al., 2022). Given this, another aim of the main study is to identify those considered credible when communicating mental health information to Muslim communities. Placing Muslim communities at the centre of mental health messaging compliments the asset-based approach further developed by our analysis. Put plainly, Muslim mental health experts must be consulted when developing mental health resources for Muslim communities.

The focus group discussion included several examples of successful community-led, collaborative approaches that are currently within faith communities to deliver faith-sensitive mental health care. *Spirit in Mind* (SIM) is part of the South-West Yorkshire NHS Trust Foundation. It aims to build community cohesion through collaboration and is a prime example of a successful partnership between faith communities and faith-sensitive mental health services. Its work demonstrates how public health resources can be used to reach into faith communities and, in return how religious expertise within these communities can be used to educate clinical staff.

The *Greater Manchester Mental Health Spiritual Care Strategy* (2019) provides another example of the successful integration of faith communities and mental health services. After consulting with service users and staff, the Greater Manchester Mental Health NHS Trust concluded that spirituality is a "central tool of agency that could help them make sense of life and find meaning" (2019, p. 11).

Both of these initiatives developed from the work of chaplaincy teams recognising the value of collaboration and knowledge exchange. Collaboration between local organisations and local, regional and national bodies is crucial if we are to develop mental health policies and services that cater to the needs of faith communities. However, it should be noted that the authors of the present article do not argue for the development

of services that are exclusively for Muslims. Instead, we wish to highlight, celebrate and amplify collaboration between faith communities and mainstream mental health providers to increase the availability and quality of services for all minority communities.

While many (84%) respondents to the survey by The Lantern Initiative (2021, p. 9) preferred faith informed counselling, it is recognised that this may not be possible in national health settings where therapies are standardised. However, respondents from the current study called for larger chaplaincy teams to include faith leaders with credible knowledge of Muslim experiences and needs. They further argued for upskilling clinical practitioners through religious literacy training, to better inform practitioners of the impact faith can play in Muslim patients' wellbeing. Established frameworks such as the *Religiously Informed, Relationally Skilful Chaplaincy Theory* (Ragsdale & Desjardins, 2022) are particularly useful and could be relied upon more often to support Muslim needs within clinical and mental health care settings.

Overall, findings strongly indicated the need for a "bottom-up" approach in which mainstream mental health providers recognise, value and utilise assets and expertise already present in Muslim communities. It is hoped that this will facilitate a step towards addressing the well documented barriers that many Muslims encounter when accessing therapeutic help.

In terms of future lines of enquiry, the analysis reported in the present article has underpinned the research design and fieldwork stages for the main study of the *Faith in Mental Health* research project underway at time of writing including interviews with Muslim community leaders and mental health practitioners. The pilot study suggests at least two other future research possibilities. First, an ethnographic study of one or more settings would further develop our knowledge of how present initiatives bridge mental health services and Muslim communities. Second, a longitudinal study exploring the implementation of more collaborative models, were they to be introduced more widely, would develop our understanding of their efficacy over time.

Conclusion

This article reported findings from a pilot study undertaken to establish the *Faith in Mental Health* research project and to explore issues concerning mental health services and Muslim communities in England and Wales. A focus group gathered faith leaders, academics, chaplains, policy advisors, psychotherapists and community organisations. Focus group data were analysed using grounded theory. Four themes emerged from the analysis: "Knowledge gaps", "Policy gaps", "Working together" and "Moving forward".

Findings highlighted the need to move beyond common narratives of stigmatisation and barriers to access and the need for credible voices to deliver mental health education, including experts of psychology and Muslim theology and practice. Based on their analysis of previous research and focus group data, the authors argued for an asset-based approach to building collaborative partnerships between Muslim communities and mental health providers.

The analysis reported in this article confirms that there are initiatives already in place in the UK that bridge Muslim communities and mainstream mental health services and that plug knowledge and credibility gaps in both. Whilst not yet recognised and implemented nationally by the UK Government, the individuals and organisations highlighted in this

article, and the insights gathered from an expert focus group, demonstrate that successful local and regional cooperation is both achievable and, given the right resources and support, highly effective. Taken together, there is strong evidence here to suggest that a more collaborative approach will improve mental health services and outcomes for Muslim communities in England and Wales.

Note

1. Focus group questions included: Are there any significant gaps in our literature review? What resources are most useful to faith communities in the UK? What resources are most useful for training mental health practitioners with clients from other faith backgrounds? What area(s) of Muslim communities and mental health should we focus on to create the most impact (e.g., community concerns, the NHS, or faith organisations)?

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