

COMMUNITY ENGAGEMENT PROJECT,
NIMHE MENTAL HEALTH PROGRAMME

REPORT OF THE COMMUNITY LED RESEARCH PROJECT FOCUSING ON
SELF DEFINED MENTAL HEALTH NEEDS OF THE MUSLIM COMMUNITY

BY SHARING VOICES (BRADFORD)

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MARCH 2006

Funded by the National Institute for Mental Health in England and supported by
The Centre for Ethnicity and Health, University of Central Lancashire



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Shaziya Younas – When I first became involved with the project I was working as a Community Development Worker at Claremont Community Centre, which is where I became aware of the project and its focus through visiting Sharing Voices and immediately decided upon volunteering as a community researcher as Mental Health interests me greatly. Having had personal experience of mental health through friends and family I felt it was important to research what alternatives forms of support have helped and assisted people through their crisis other than the conventional methods currently available.

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ACKNOWLEDGEMENTS

The community researchers would like to express their sincere gratitude to the 87 individuals who participated within the research, sharing their personal thoughts, experiences and spiritual journeys, without whom this project would not have been a success. Dr Phil Thomas has been an inspiration and always been available to offer his invaluable advice as well as his continuous support and encouragement. All of the steering group members for their knowledge, guidance and individual expertise. UCLAN, NIMHE for choosing Sharing Voices (Bradford) as a pilot project and finally the continuous support of the previous and current manager of Sharing Voices (Bradford).

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7. Executive summary

It is widely recognised that BME communities experience social and material disadvantage and face barriers in their access to statutory support services. Social exclusion is a symptom and product of institutional racism and stereotypes. Within a health context social exclusion and institutional racism have contributed towards significant differences in health outcomes for BME communities including Muslim communities.

The mental health system and in particular the notions of the self and distress are 'Eurocentric' and exclude, to the detriment of the Hippocratic Oath of 'doing no harm', alternative cultural, ethnic, gender and spiritual perspectives. Within the 'system' even western traditions of spirituality are ignored and preference is given to a biomedical model which while acknowledging the causes of peoples distress fails to adequately engage with peoples experiences. De-contextualisation of people from their experiences, culture, notions of their self, religion and spirituality leads to inequalities in mental health outcomes. This study focuses on the self defined mental health needs of the Muslim community and provides local Muslim people the opportunity to define and describe their own perceptions of their identities and what they see as key components of a mental health service which has 'choice' as a central and guiding principle.

This project was funded by the National Institute for Mental Health in England and supported by The Centre for Ethnicity and Health, University of Central Lancashire (UCLAn) using the Community Engagement Model. This study was undertaken by Sharing Voices (Bradford) an organisation that engages people living with mental distress through the conceptual and practical tools of Community Development and Post Psychiatry. SVB engaged, identified and trained two community researchers and involved some 87 people from a broad spectrum of the Muslim community of Bradford. The research was guided by a steering committee comprised of local stakeholders including Selina Ullah (Race Equality Lead, NIHME) CCCMH, Bradford District Care Trust, Bradford City tPCT, FIS Manager, a community researcher and by the University of Central Lancashire who also hold overall responsibility for the community engagement pilots.

Findings

The study found that Muslim participants talked around five distinct themes including;

Politics and Personal Identity

"I'm a Muslim and that would never change, my faith makes me who I am"
(FG 18-25 Women)

"...My identity for me is...I'm a Muslim British Pakistani" (FG 18-25 Women)

Faith and Lifestyle

“...It helps us move forward or we would be lost...it gives you comfort and strengthens you as a person, and keeps me sane.” (FG 26-40 Women)

“For me personally Islam shapes my life for example I would not work in a place if I cannot fulfil my Islamic duties, my prayers...I will look elsewhere for a job where I can both work and pray I see it as important aspect of my life” (FG 18-40 Reverts Men)

Identity and paranoia

“I don’t personally walk around with this paranoia but I think as a group the connotations attached to Muslims generally are very negative...and I think that is related to what is going on at the moment across the globe” (FG 18-25 Women)

“...Someone at work asked my name...he said I find it funny and some what ironic that this government employs the same people who are from the group of people who bomb the capital city in our country...” (FG 18-25 Male)

“...I no longer feel comfortable getting on the train because everyone just looks” (FG 26-40 Women)

Individual racism

“As a Muslim I feel I am not treated as well as others, this could be on a bus, with no reply to even my simplest thank you or please” (FG 26-40 Men)

“I’m a Muslim revert...but when I had an “episode” was given a curry...I’m not being disrespectful but I don’t eat curries, its not good for my ulcers...yet because you’re a Muslim, they assume you’ll eat curry”. (FG 18-25 Men)

Community denial

“In our community there’s this thing called baste, shame, when someone’s child’s got mental health problems the word is spread and it’s a big shame” (FG 18-25 Male)

Participants also discussed and brought into the open views on stigma, language and alternative forms of support, gender specific issues, institutional racism and social exclusion.

The study found that participants had a clear idea of what helped them in times of distress as a result of which the following key recommendations were made:

1. Gender specific safe spaces and community-based Alims

- Resources should be made available to employ Alims/Alimas (male and female scholars) based within the community.
- Safe spaces in both statutory services and in the community should be developed and promoted.
- Development of and access to information and advice facilities that are targeted at people living with mental distress and their families.

2. **Choice**
 - Offering choice to Muslim people in Bradford includes provision of above as well as Hakims and Faith-based Resources.
3. **Cultural Competency and Good Practice in Services**
 - To provide and develop bespoke training packages for staff working within statutory and third sector organisations.
 - This approach to be developed in partnership with voluntary sector organisations that have expertise in working with BME communities and are culturally competent themselves.
4. **Employing culturally competent family support**
 - To employ a series of family support workers who would work to develop family centred services that promote family well-being and enable families to cope with mental health crisis in a relative, partner, parent and or sibling.
 - Family support workers to act as a conduit through which services can improve and adequately meet the needs of people.
5. **Governance and Quality/Training**
 - To provide and develop bespoke training packages for staff working within statutory and third sector organizations. This approach needs to develop in partnership with voluntary sector organisations that have expertise in working with BME communities and are culturally competent themselves.
6. **Strategic Planning and Implementation**
 - This report and its recommendations be included in the FIS action plan which aught and hopefully will cut across all agencies that are interested in enabling people living in mental distress to recover.

Conclusion

This study and the themes that emerge are not new, they reaffirm much of what is known already. It is clear that people have and continue to experience social exclusion and live with stigma, racism and Islamaphobia and have clear personal and social identities that are informed by their faith and beliefs. They are also certain and articulate and suggest to service providers responses that would be congruent with their needs and which crucially offer 'choice' and thus increase the possibilities of recovery and non medical interventions. The study will only be of value if they recommendations proposed are taken forward and implemented and a timescale for reporting back the outcome to the community is set in motion.

2. INTRODUCTION

2.1 The Centre for Ethnicity and Health's Model of Community Engagement

Background

We often hear the following words or phrases:

- Community Consultation
- Community Representation
- Community Involvement/Participation
- Community Empowerment
- Community Development
- Community Engagement

Sometimes they are used inter-changeably to mean the same thing. Sometimes the same word or phrase is used by different people in the same meeting to mean different things. The Centre for Ethnicity and Health has a very specific notion of Community Engagement, and this paper is an attempt to describe it. The Centre's Model of Community Engagement evolved over a number of years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The Department of Health had two key things in mind when it commissioned the work; first, the Department of Health wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done. If all the Department of Health had wanted was a needs assessment and a 'glossy report', they could have directly commissioned a number of researchers who could have gone into local Black and minority ethnic communities, talked to them about their needs, written up a report, and produced yet another set of reports that potentially do not have any long term impact. This scheme was different however. The Department of Health was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; what they would have is proven access to the communities they were working with, the potential to be supported and trained and the infrastructure to conduct such a piece of work. They would be able to use the nine month process to learn about drug related issues and about how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity & Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned about drugs, and learned about the needs of their communities, and they would be able to continue to

articulate those needs to their local service providers, and their local Drug Action Teams. It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas or domains of work. These include:

- Substance Misuse
- The Criminal Justice System
- Sexual Health
- Mental Health
- Regeneration
- Higher Education
- Asylum

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- Young people
- People with disabilities
- Service user groups
- Victims of domestic violence
- Gay, lesbian and bi-sexual people
- Women
- White deprived communities
- Rural communities

In addition to the Department of Health, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, The National Institute for Mental Health in England, the Greater London Authority and Aimhigher.

2.2 The Key Ingredients

According to the Centre for Ethnicity and Health model, a Community Engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a **host community organisation**. This may be an existing community group, but it might also be necessary to set a real or virtual group up where one does not exist already. The key thing is that this host community organisation should have good links to the target community¹ (whoever this is) such that it is able to recruit a number of people from the target community to take part in the project and to do the work (see section on task below). It is important that the host

¹ The target community may be defined in a number of ways – in many of the Community Engagement Projects that we have run we have defined it by ethnicity. We have also worked with projects where it has been defined by some other criteria however, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. drug users or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with or rally around (e.g. victims of domestic violence, sex workers).

community organisation is able to provide co-ordination and infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day to day activities that will be undertaken once the project is underway. One of the first tasks that this host community organisation undertakes will be to recruit a number of people from the target community to work on the project.

A Host Community Organisation	With Good Links To The Target Community	To Provide Basic Infra-structure For The Project (Recruit And Co-ordinate Project Team; Provide Office Space, Phones And Computers; Look After The Finances)	To Recruit A Number Of People From The Target Community To Do The Work
A Task	Time Limited Meaningful Manageable	A Piece Of Research Into Key Needs/Gaps/Issues For The Community	Learning And Development Of Key Individuals; Access Hard To Reach Groups; Raise Awareness and Debate; Community Ownership
Support	Financial (Typically Up To £20,000)	Training And Workshops; On-Going Support And Guidance; Personal Tutor	Statutory Partnerships; Steering Groups; Sustainability

The second key ingredient is the **task** that the community is to be engaged in. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects that we have run have involved communities in undertaking a piece of research or a consultation exercise within their own communities. Sometimes we have been met with an initial resistance to doing ‘yet another piece of research’, but this misses the point. As in the initial programme that we ran on behalf of the Department of Health, *the process (i.e. of getting ordinary people involved in doing the work) is as important, if not more important, than the report that they produce at the end of the day.* The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be *the first time that these individuals have undertaken a research project.*

The final ingredient, according to the Centre for Ethnicity and Health’s model, is the provision of appropriate **support** and guidance. We do not expect community groups to become involved for nothing. Typically we would make in the region of £15-20,000 available to the host organisation. We would expect that the bulk of this money would be used to pay people from the target community as community researchers². We then allocate a named member of staff from our Community Engagement Team as a project support worker. This person will visit the project for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers through the project. We also provide a package of training – typically in the form of a series of accredited workshops. The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to pull together a steering group for the project³. The steering group is an essential element

² This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

³ Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

of the project: without one, it is difficult to see who the community are engaging with and it is unlikely that anything out of the project will be sustained in the longer term. The group will be doing a needs assessment or a consultation exercise, but for what purpose? It is the role of the steering group to ensure that the work that the group undertakes sits with local priorities and strategies, and that there is a mechanism for picking up the findings and recommendations that the group may make. It is also their role to help to pick up the key individuals who are developed through the project process to help them to take their ‘next steps’.

2.3 The Community Engagement Team

The Community Engagement Team comprises of 25 members of staff. They work across a range of Community Engagement areas of specialism, within a tight regional framework.

National Programme Directors			
Northern Team	Midlands Team	Southern Team	Senior Programme Advisors
Senior Support Worker	Senior Support Worker	Senior Support Worker	
Support Workers X 3	Support Workers X 3	Support Workers X 6	Drug Interventions Programme
			Regeneration
			Mental Health
Teaching And Learning Team			
Administration Team			
Communications Officer			

2.4 Programme Outcomes

Each group involved in any of our Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community that it consulted with. The qualitative themes that emerge from the reports are often very powerful, particularly when taken together with other reports produced by groups involved in the same programme. Such information is key to commissioning and planning services for diverse and ‘hard to reach’ communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

3. Bradford Community Engagement Pilot Project: The Focus of This Particular Report

Since 2000 over 200 community groups have taken part in one or other of the Centre for Ethnicity and Health's Community Engagement Work Programmes. The researchers would like to categorically express that the views in this report are those of the group that undertook the work, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire.

In this section we will set the scene and provide details of the context in which the project has emerged and developed. The project will focus on the needs of the Muslim communities in Bradford to ascertain their views on mental health and possible solutions.

National Institute for Mental Health in England Community Engagement Programme:

Sharing Voices (Bradford) was one of the 11 pilot community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme in 2005-2006. The objectives of the programme were to improve equality of access, experience and outcomes for Black Minority Ethnic Community service users by:

- *Building capacity in the non-statutory sector*
- *Encouraging the engagement of Black and minority ethnic communities in the commissioning process*
- *Ensuring a better understanding by the statutory sector of the innovative approaches that are used in the non-statutory sector*
- *Involving Black and minority ethnic communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services*
- *Ensuring greater community participation in, and ownership of, mental health services*
- *Allowing local populations to influence the way services are planned and delivered*
- *Contributing to workforce development, and specifically the recruitment of 500 Community Development Workers.*

3.1 Bradford – Contexts

Like many industrial Pennine towns, Bradford's population reflects the multicultural nature of modern British identity. The population of the city in the 2001 census was just under 468,000, of whom 14.5% described themselves as Pakistani, 2.7% Indian and 1.1% Bangladeshi. The city has a significant Muslim community; at 16.1% this is the fourth highest figure in the country. The demography of the city's BME community is evolving, with growing numbers of British-born Muslims, Hindus and Sikhs. These figures fail to reveal the way in which the city's BME communities are concentrated in the inner city areas.

There are important implications for the health of the residents in key areas across the District. Figures from the National Database for Primary Care Trusts indicate that Bradford City tPCT ranks fifth in England in terms of having Super Output Areas (SOAs) that are in the 20% most deprived in England. In other words the health of the residents of inner city Bradford is more likely to be adversely affected by socio-economic factors such as poor housing, overcrowding, and unemployment, than that of the residents of more prosperous parts of the city, or for that matter most other parts of the country. Social adversity and poverty disproportionately affect people from BME communities, and this is reflected in their experiences and use of mental health services, as the recently published NIMHE / Department of Health report *Inside Outside* has highlighted (2003).

3.2 The Values of Sharing Voices Bradford

The theories of psychiatry continue to dominate practice in mental health services in this country. Bracken and Thomas (2005) have argued that although some aspects of recent government health policy such as the *NHS Plan* (HMSO, 2000) and *Delivering Race Equality* (DH, 2003) are driven by the democratic ideals of greater patient involvement in the planning and delivery of services, and the imperative to combat social exclusion and health inequalities, the National Service Framework for Mental Health (DH, 1999) is dominated by medical interpretations of distress, stressing the importance of medical and psychological interventions for people who experience psychosis and distress. Such interventions are deeply rooted in Western assumptions about the nature of the self, and although many people find such services helpful, this is not the case for those from non-Western cultural traditions. This is because 'mental health' problems have strong personal, social and cultural dimensions and cannot be understood in biological terms alone. In psychiatry, the context in which such problems arise is often ignored and alternative ways of understanding states of sorrow, withdrawal, madness and dislocation are marginalized or even pathologised (Bracken & Thomas, 2005). These issues demand responses to contexts and communities in imaginative and flexible ways.

Sharing Voices Bradford was set up in August 2002 specifically to tackle these problems. It does so by recognising the primary importance of cultural, spiritual and social contexts that frame individual experiences of distress. It is these contexts that shape the *meaning* of individual experiences of distress, and it is only by paying attention to the possible meanings of experiences that people can move on to recovery. So, by using a model of community development, SVB works with local communities to develop networks of support that can help those who experience severe distress to make sense of their experiences and thus move forward in their lives.

Distress is experienced within, and is shaped by, different cultural understandings of the world, and of suffering and healing. This calls for solutions that use different ways of framing, and responding to, difficulties. Crucially, this means that this research project must engage with Muslim communities, with their knowledge and their strengths.

Sharing Voices Bradford has much experience in participatory research of this nature. It has recently been involved in participatory research partnerships with the

International Centre for Participation Studies (ICPS part of Peace Studies) in the University of Bradford in *Participation, Why Bother* Project, and the Sainsbury Centre for Mental Health. It is currently involved in a third, *Minorities in Minorities*, jointly with ICPS and the Centre for Citizenship and Community Mental Health (CCCMH).

3.3 Islam and Psychiatry

“Islam is the religion whose founder is the Prophet Muhammad (pbuh⁴). A Muslim is an adherent of the Islamic religion. Muslims represent the majority in 56 countries, and form more than one-fifth (1.2 billion) of the world population”. (*Psychiatry and Islam, 2004*)

Within these varied Muslim communities faith and spirituality plays a central role in day to day living and provides people with strategies that promote individual and societal well-being. Within the definition given above Islam is defined as a religion however the Quran (according to Muslims, the revealed word of Allah) describes Islam as ‘Deen’, literally a way of life, encompassing all spheres from the mundane to the spiritual, political and educational. The Quran and the life of the Prophet Muhammad (pbuh) serve as important reference points for a Muslim, a family, community and or country. The Islamic way of life is concerned with developing human being’s by creating a state of balance to live healthy and rewarding lives. As such spirituality and or cultivating closeness to Allah has always been the central focus of a Muslim’s life whether it is in the arena of social interaction, business and commerce, marriage, education and or social welfare. The individual is reminded of responsibility to Allah and to creation and shows practical examples of how to go about this.

It would therefore become apparent that the Islamic view of health and well-being is holistic and encompasses the whole and is a state of ‘being Muslim’ literally translated as ‘one who submits’. Therefore mental health or well being in Islam is seen as part of the daily practical life and also the observance of religious duties.

“*Verily in the remembrance of Allah do hearts find satisfaction*” (13:28 Al Quran)

However within an Islamic framework there is also an acceptance where it may be that for some people this balance may become disrupted and people may become temporarily unwell. Therefore, in Islam and Islamic societies processes have been developed to enable individuals to recover from mental distress and also a different conceptual framework for defining/diagnosing mental illness, but do not necessarily match that of mainstream psychiatry / psychology.

Central and core to this process is that the person needs to maintain a sense of direction and anchoring and retain observance of prayer, fast and Dhikr⁵. This could also be complemented in the formal way of seeking a spiritual guide and or healer who, having travelled and mastered the spiritual sciences, would be able to

⁴ Peace be upon Him (the phrase mentioned as a sign of respect after mentioning the name of the Prophet Muhammad)

⁵ Remembrance of Allah

recommend and prescribe litanies to people to recite in order to rectify ailments such as feeling alienated, hopelessness and so on.

Sufism⁶, ilm al nafs or Tasawuf is the traditional (all commonly understood to mean the ‘science of the human soul’) and important aspect of traditional Islam which deals with enabling people to develop knowledge of God and to experience peace. The Sufi⁷ thought and literature is highly developed and sophisticated and deals with this science as a systematic process. Here it is important to note that science within Islamic tradition is observable, repeatable and quantifiable and also deals with the abstract and metaphysical in a manner that is uniquely Islamic. Indeed Muslim scientists initiated and developed both forms of ‘science’. This questions the current notion and self-deceit of psychiatry which claims for itself a scientific medical status. Contemporary psychiatry at worst rejects societal, environmental and spiritual aspects of distress and suggests almost entirely somatic or bodily interventions. Whereas Islam in the branch of Sufism places human beings between physical and metaphysical realities and argues that both are science. The place of Sufism has been central throughout Muslim history and as such one will find ‘Sufi Orders’ that focus on developing people’s closeness to God through religious observances, refraining from bad action and promoting good. Examples of refraining from bad action would be not to lie, cheat, or usurp other peoples rights and promoting good could entail removing harm from people, preaching, supporting orphans etc.

Deriving mainly from the Sufi understanding of the self, structured approaches to the treatment of states of psychological distress have developed. This area of therapies is namely described as “Tibb ul naffs” of “Nafsiyat”. The therapeutic practises within the tradition include the specific use of music and approaches to talking psychotherapy. Some of these approaches have evolved into western practises, as in some aspects of Jungian analysis and in trans-personal psychology, which was developed by a follower of the Chisti⁸ Sufi order.

The other component of Islam’s approach to mental health well being was the development of medicine or ‘Tibb’ based on the four humors (Yellow Bile, Black Bile, Phlegm, Blood), as well decoctions of herbs and plants and foods e.g. honey. Central to these was an understanding of how the Prophet lived and his habits of eating and drinking and it is implicitly believed that Prophetic advice in this area promotes good health and well-being. Thus the central aim of Islamic medicine would be as Avicenna points out:

“The art which is concerned with the preservation of good health, combating disease and restoring health to the sick” cited in the introduction to Natural Healing with the Medicine of the Prophet, Imam Ibn Qayyim Al-Jawziyya (1292-1350 C.E.)

The Prophet Muhammad (pbuh) said: *“Allah has not sent down any malady but he has also sent down the remedy; those who know it, know it, and those who do not know it, do not know it”* narrated by Ahmad, 3397.

⁶ Sufism, ilm al nafs or Tasawuf is a branch of Islam that focuses on the direct perception of Truth or God through mystic practices based on divine love

⁷ Sufi : an individual on the path of Sufism

⁸ Chain of Sufi orders

As Islam spread to many different lands one of the first psychiatric hospitals arose in Baghdad in 705 CE followed by Cairo in 800ce and Damascus in 1270ce. The first specific specialist psychiatric ward was built adjoining general hospitals in Turkey in 1555. (This even experimented with music therapy and sound vibrations/resonance).

Some of the great Muslim physicians include al-Razi (d.925) who wrote a 24 volume encyclopaedia of medicine and ibn Sina (Avicenna; d 1037) who wrote the 14 volume *“The Cannons of Medicine”*, which was used in the west for 700 years. Both worked with psychiatric patients, with ibn Sina rejecting the notion that mental illness was caused by evil spirits (Jinns)⁹. However Al-Ghazali criticised ibn Sina’s view on the notion of mental illness and Jinns⁹, who believed Jinns and other spiritual factors did contribute towards mental illness.

From the above it becomes apparent that Islam has a fully developed system in place that sees faith and spiritual works as central to promoting the well-being. Crucially important is that in Islam there is no gender imbalance and the above is equally valid to Muslim women as it is to men.

“For Muslim men and women, for believing men and women, for devout men and women, for true men and women, for men and women who are patient and constant, for men and women who humble themselves, for men and women who give in charity, for men and women who fast (and deny themselves), for men and women who deny guard their chastity and for men and women who engage much in Allah’s praise-for them has Allah prepared forgiveness and great reward” (33:35 Al Quran)

In conclusion “There is a desire held by sizeable proportion of Muslims for the retention and resuscitation of traditional teachings and the core values of compassion, justice and benevolence that characterise all world faiths, including Islam”. (*Psychiatry and Religion, 2004*)

It becomes apparent from the above that Islam as a faith tradition of Muslims is full of depth that promotes individual and societal well-being, Muslims see their well being symbiotically linked to faith and practice of their ‘way of life’, Islam.

3.4 The Study

The focus of the Community Engagement Project at Sharing Voices (Bradford) in line with the government’s vision of improving engagement, information, access and choice, is to engage Muslim service users and the Muslim community to help them articulate their understandings of mental health, their priorities and agendas. The project specifically focused on 18-40 year old Muslim Men and Women in order to support local people identify and articulate the range of support and interventions that meet their needs.

Aims:

1. To enable Muslim people in Bradford between the ages of 18-40 to describe

⁹ The Jinn are beings created with free will, living on earth in a world parallel to mankind. The Arabic word Jinn is from the verb *‘Janna’* which means to hide or conceal. Thus, they are physically invisible from man as their description suggests (<http://www.islamawareness.net/Jinn/world.html>).

how they understand the relationship between their faith, their personal identity and the cultural and political context we all live in.

2. To enable Muslim people between the ages of 18-40, to describe how they see the factors and relationships in Aim 1 impinging on their emotional well-being and or mental health.
3. To enable Muslim people to describe how they see the contexts in Aim 1, as influencing their choice of support and help when they are in crisis or in time of need.

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Objectives:

1. Building capacity in the non-statutory sector by recruiting, training and resourcing community researchers to undertake research.
2. To establish links with interested parties – local people, academics, services and institutions to guide and direct the project through establishing a Steering Group.
3. Encouraging the engagement of the Muslim communities, groups, mosques and leaders in terms of their understanding and perspectives on mental health and the aims of the project.
4. Ensuring a better understanding by the statutory sector of the innovative approaches within an Islamic framework that are used in the Muslim communities.
5. Involving the Muslim communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services through conducting focus groups and semi structured interviews.
6. Allowing local Muslim community to influence the way services are planned and delivered
7. To disseminate the key themes and recommendations highlighted throughout the field work.

4. Methodology

4.1 Recruitment/Networking:

We wanted to access views and opinions that are normally excluded from debate and difficult to access, so we used a participatory research model. Sharing Voices (Bradford) appointed a part time Community Development worker (CDW) to take the lead in delivering the Community Engagement project. Through SVB's existing networks the CDW conducted a number of presentations at several community centres/organisations describing the proposed research. As a result of this we recruited two community researchers (Sami and Shazia). The third and final individual to participate with the project was a service user, who volunteered to become a community researcher after visiting SVB.

Although the majority of the Muslim population in Bradford is of Pakistani origin, it was important to recruit subjects from a variety of ethnic backgrounds in order for the study to be representative in terms of diversity. In order to increase the validity of the data obtained from the focus groups and research interviews, we tried to ensure that as far as possible interviewers matched interviewees as closely as possible in terms of

languages spoken, gender, age and cultural origin. The diverse cultural origins of the community researchers meant that this was possible.

Researcher	Ethnicity	Age
Sami Babiker	African	30
Noreen Hussain	Bangladeshi	21
Fozia Sarwar	Pakistani	28
Shazia Younas	Pakistani	27
Kamran Yunis	Pakistani	24

Having recruited the researchers it was important to identify key stakeholders who would steer and supervise the direction of the project. The networks and links established by Sharing Voices were once again invaluable as key individuals across organisations nominated themselves to become members of the steering group, which consisted of leaders of the Muslim community, Muslim service users, an independent community advisor, Individuals from both the voluntary and statutory sector including CCCMH (Centre for citizenship and community mental health), Local Implementation Team (LIT) and commissioners from the Primary Care Trust were also invited to join the steering group. Involving commissioners was essential to develop sustainable provision and it was hoped that this involvement will enable the themes that emerge from the research to be integrated into current services and new service provision. Over time this forum became important in ensuring that the project’s aims and objectives were achieved. Throughout the duration of the project the steering group convened four times.

4.2 Training:

The University of Central Lancashire provided initial training for the community researchers, which consisted of six workshops. The first two workshops included: Understanding Mental health – key themes, overview of national policy and service implementation framework for mental health and a historical overview of mental health policy development. Workshops 3-6 included, what is research, overview of different research methods, primary and secondary data sources, quantitative and qualitative methodology, ethics and confidentiality. The final workshop concentrated on writing and dissemination of the report. The training provided the researchers with the necessary skills and theory to conduct and carry out the research in an objective and non judgmental manner. The researchers were provided with ongoing support from the SV (B) management. In addition, the daily support from the senior community development worker proved crucial at times.

4.3 Devising Research Questions:

Immediately preceding the training workshops the group began work on the research methodology. Regular fortnightly meetings were held between the researchers and the support worker, to discuss this, and decide on what research tools to use. We felt that there were serious disadvantages with quantitative methods and structured questionnaires. They seemed too objective, cold and impersonal, and thus alien to people from Muslim communities. We also believed that closed questions were inappropriate in questionnaires in a study of this nature, given the sensitive, difficult and complex nature of the beliefs and experiences we wanted to access. In addition, it was likely that such questions would be loaded with assumptions, and lead

interviewees in directions that did not fully represent the views and opinions of the Muslim Community.

In view of this, the research group decided to use qualitative methods with focus groups and in depth interviews, using a semi structured interview schedule. This allowed participants to speak freely and fully about their personal experiences of mental health in a group or one to one setting. We felt that focus groups personalised the experience of being involved in a research project. The data extracted from the focus groups would be rich and capture personal anecdotal experiences of those who had experienced distress, and the response of Mental Health Services.

The focus group schedule is presented in appendix 8.1 and consists of six questions. We decided to use these questions after extensive discussion with the researchers, steering group members and also the support worker from UCLAn. They cover two main areas. Questions four and five are directly concerned with individual experiences of mental health services, as well as the type of support that people feel in necessary when in crisis. Questions one, two and six deal with the wider cultural and political factors that the groups felt were important in understanding how British Muslims might make sense of their experiences of distress, particularly in terms of personal identity and the wider political context. Finally, question three invited research subjects to make a link (if appropriate) between the issues of politics and identity, and experiences of distress.

4.4 Carrying out the Research

Once we had decided on the research methods and tools, the community researchers explored the possible breakdown of the focus groups in order to engage as many individual views as possible from the Muslim community. We were interested in the experiences of those who had used both primary (GP) and secondary (specialist) services. It was agreed that the researchers would complete six focus groups, all gender and age specific. These groups were organised as shown below:

Focus Group	Age group	No. Of Individuals	
		Male	Female
1 Mixed	18-40	6	2
2 Gender specific	18-25	10	15
3 Gender specific	26-40	10	14
4 Convert/Black Muslims	18-40	12	8
5 Those visited GP only	26-40	0	0
6 Those using secondary services	18-40	0	0

The final two focus groups, 5 and 6, were incorporated within the first three focus groups. A detailed breakdown of each focus group, illustrating the ethnicity, citizenship, languages spoken and written and the range of ages is available at appendix 8.3 and appendix 8.4 for the semi-structured interviews.

It was agreed that all focus groups would incorporate individuals with disabilities. The engagement worker delivered several presentations at a number of organisations

highlighting the make up of the focus groups and it was envisaged that they would incorporate individuals with disabilities. Although attempts were made through existing networks, the focus groups failed to incorporate individuals with disabilities. This was due to time limitation, limited resources in terms of transport and a suitable and accessible venue.

It was also agreed that the community researchers together would conduct between 10-15 semi-structured interviews. This was primarily for individuals who were unable or not comfortable with participating in the focus groups and who did not express their views. However there were also subjects who did not feel confident enough to speak in the group and preferred to voice their experiences on a one to one basis. The purpose of the interviews was to complement the information gained from the focus groups and would also allow for case studies to be incorporated within the final report.

4.5 Data Collection / Identifying participants

The community researchers through their informal networks, relatives and place of employment began identifying individuals from the Muslim community who had direct mental health experiences to participate within the research. According to the project plan (appendix 8.5), dates were set for the focus groups to take place in late November and throughout December 2005. On a few occasions individuals did not attend the focus groups due to inappropriate settings. This was discussed within the bi-weekly meetings where the researchers highlighted requests made by subjects for a more convenient and comfortable venue, one which was suitable for them. The feedback from the participants was positive and the numbers of people willing to partake within the research was between 85-90. The focus groups were held in a diverse range of settings, including SVB, a local community centre, a local café and by request at an individual's apartment. This provided a safe space where individuals felt comfortable and at ease to speak about their personal experiences.

The semi-structured interview dates were set for early January. Similar to the focus groups, participants were recruited and identified through a wide range of SVB's networks including the acute admission wards at Lynfield Mount Hospital, statutory and voluntary organisations and the networks established by the Community Engagement worker in the Muslim community, which included Muslim scholars (Alims) and elderly leaders. This proved essential in attracting individuals who wanted to share their opinions and experiences of distress and mental health services.

Preceding the focus groups or interviews a confidentiality statement was read out to all of the participants and they were requested to complete a consent form and a core questionnaire set by UCLAn (appendix 8.6,8.7,8.8). Individuals were informed that the facilitators would be taking notes and the discussions would be recorded in order to analyse the data collected. This was important to capture key quotes that would strengthen emerging themes and recommendations. Each focus group and semi structured interview was recorded with the key questions on paper for both the participants and facilitators, as it was felt this would help them remember the question and prompt them in case they digressed. Each focus group was allocated two hours. Individuals were reluctant to answer the initial question, however once subjects became comfortable and heard of other participants' experiences the atmosphere

relaxed, allowing people to speak openly about their experiences and encounters. The problem was not then sparking further discussion, but ending it, as several focus groups overran by two hours and on other occasions three hours. This highlighted the vast quantity and richness of data that was being presented, but also captured the need for open dialogue where individuals could express themselves, their opinions and experiences freely without feeling scrutinised.

4.6 Data Analysis

Upon completing the field work the task of transcribing began. The responsibility of transcribing both the recordings and the notes taken was equally shared between the community researchers and also the senior CD Worker. The advantages of recording the focus groups and semi structured interviews became evident through the process of the transcription, as information or quotes that may not have been noted were re-captured and themes that may not have been recognised during the focus groups or interviews were emerging. The transcribing process was extremely time consuming but highlighted once again the depth and richness of the data collected.

When the recordings of the focus groups and semi structured interviews were transcribed the researchers began analysing the transcriptions. We followed the procedure set out by the UCLAn (University of Central Lancashire) training, which began by highlighting emerging themes parallel across all seven focus groups. The themes identified in subjects' responses were related in broad terms to the areas covered by the six questions, as described in the method. Questions one, two and six related to personal identity and the wider political context, questions four and five related to experiences of distress, and question three explored the relationship between identity, politics and distress.

5. Findings:

5.1 Core Data

The core data for all participants in this research project include: A total of 87 participants were contacted:

- Focus groups 75
- Semi-structured interviews 12

Out of which:

- Female Participants 43
- Male Participants 44

When asked about their sexuality, all 87 subjects reported that they were heterosexual.

Figures 1.1 and 1.2 illustrate the diversity of the sample and how the distributions of male and female participants were similar in terms of ethnicity.

Figure 1.3 illustrates the length of residence within the United Kingdom (UK). Individuals over 30 years are resident since birth.

Figure 1.4 illustrates the diversity of the languages spoken amongst participants. Although English may have been their first language, participants often described their experiences using terminology they understood and were able to explain in their own language.

Figure 1.5 Illustrates languages written by participants.

A detailed breakdown of the core questions for all participants can be found in appendix 8.3.

5.2

Figure 1.1

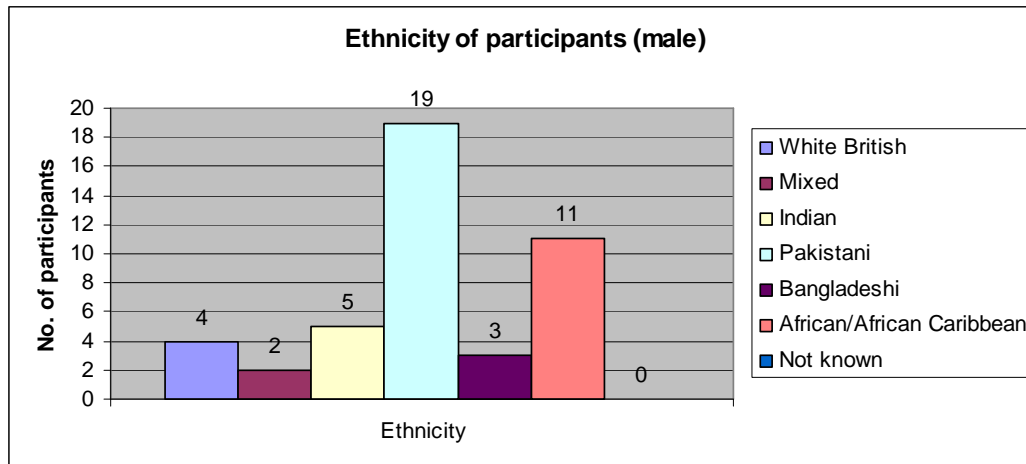
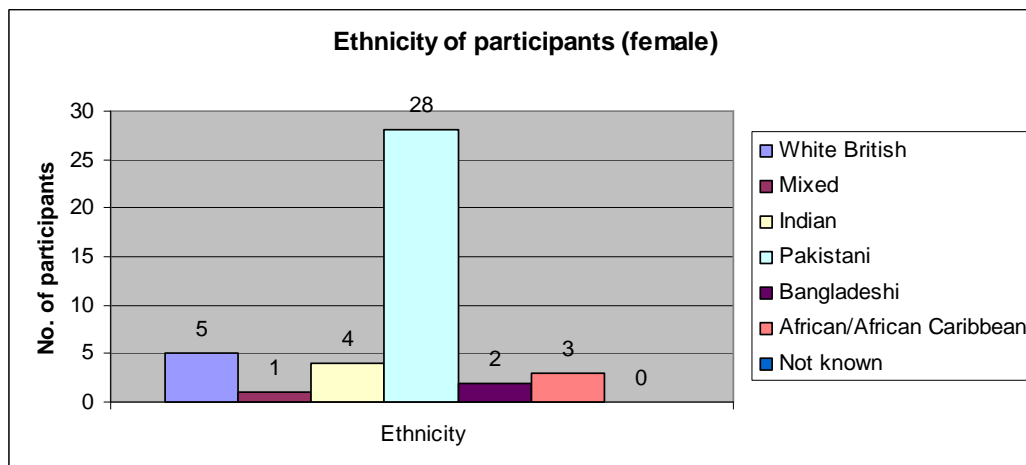


Figure 1.2



5.3

Figure 1.3

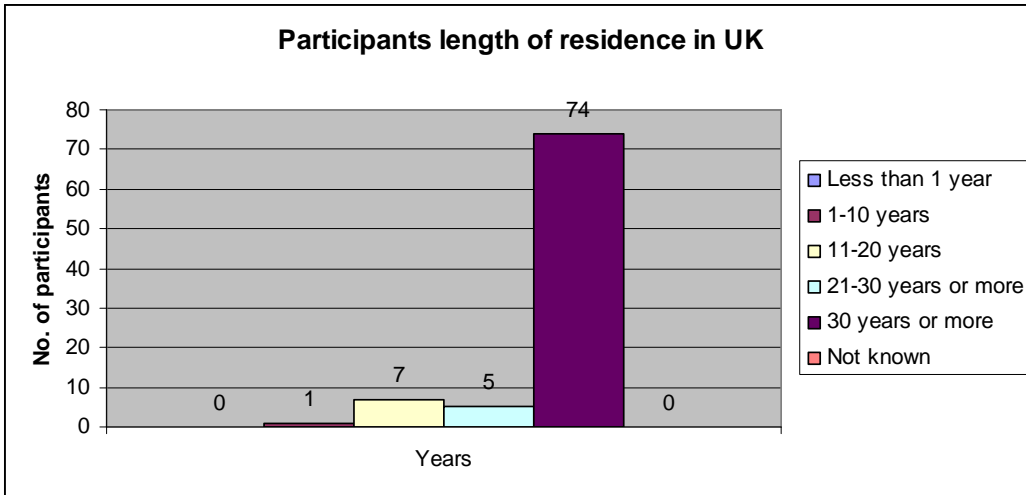


Figure 1.4

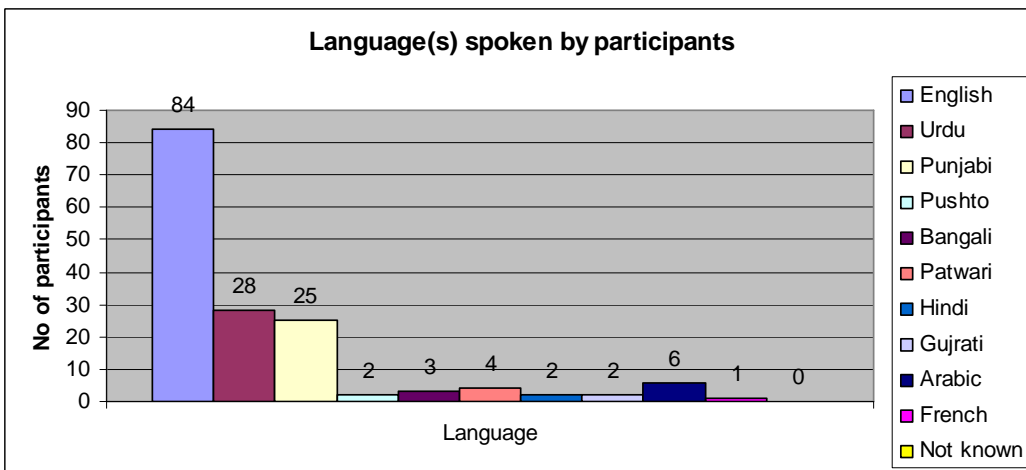
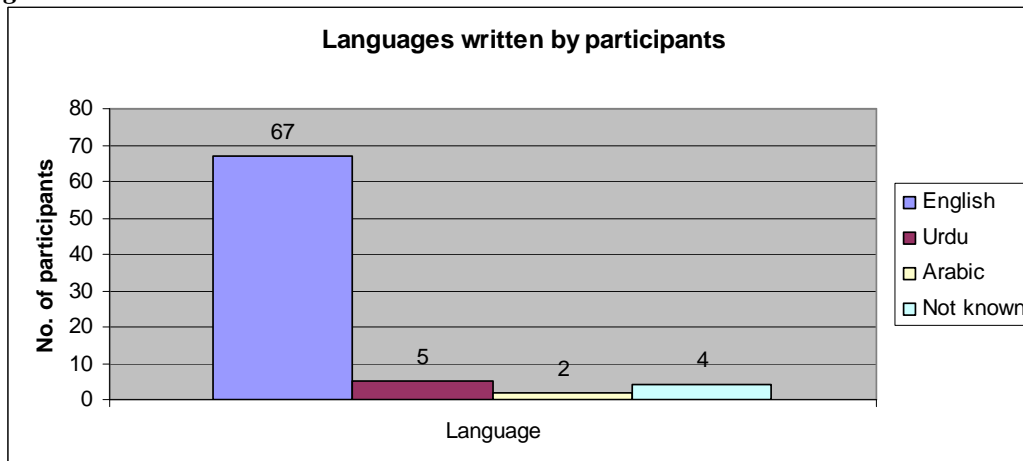


Figure 1.5



6. Results

In order to simplify the presentation of the results the researchers decided to present them in three sections. The first summarises the responses to questions 1, 2 and 6 (appendix 8.1), which considered how subjects understood themselves and their identity. The third section summarises the responses to questions 4 and 5 which deals with subjects experiences of mental health services and their perceived needs for support when in crisis. The second section summarised responses to questions 3 which examines whether in the subjects' views, there is a link between the first and third sections.

6.1 Section One: Questions 1, 2 and 6

Five themes emerged in subjects' responses to these questions. These themes were apparent across all the focus groups. We called these themes politics and personal identity, faith and lifestyle, identity and paranoia, individual racism and community denial.

Politics and Personal Identity:

In all seven focus groups participants spoke about their personal identity. Many, if not all, agreed that their faith was central to their existence. There was an overwhelming perception of Muslim identity, followed by Pakistani, British, African and so on.

"Muslim not British or Pakistani"

(FG 18-25 Men)

"I'm a Muslim and that would never change, my faith makes me who I am"

(FG 18-25 Women)

"...My identity for me is...I'm a Muslim British Pakistani"

(FG 18-25 Women)

Differences emerged between men and women. Some female participants described their personal identity through the practical implications of their faith for example the wearing of the hijab¹⁰ or the veil.

"...My identity for me, my hijab is very important the way we dress...our religious beliefs"

(FG 26-40 Women)

¹⁰ Hijab refers to a headscarf. In Islamic scholarship, hijab has a larger meaning: dressing modestly (<http://en.wikipedia.org/wiki/Hijab>).

“Yes but with a hijab I think that’s universal and people wear that because that is part of their identity”

(FG 18-25 Women)

Nevertheless, there was a general consensus that even in the absence of external markers or symbols such as the veil; women felt that their faith was central to defining their identity.

For some of the male participants having a beard appeared to cause complications. However for others it was an important aspect of their identity. This suggests that participants were grappling with complex internal debates enabling them to alternative pathways in living in a secular society, whilst adhering to their religious framework.

“...for us to be safer here, it’s better for me to not have a beard, so I can fit in better with the society...you’re not excluded...yet having a beard does kind of set up barriers”

(FG 18-40 Reverts Men)

“...For me having a beard is about my identity...people know who I am and I feel comfortable with that”

(FG 18-40 Mixed Group)

“I don’t think being a Muslim is how you dress, it’s how you act and your character. It’s not about having a beard”

(FG 18-40 Revert Male)

It is clear that for some people, identity as a Muslim had to be understood in terms of the current context:

“I’m not threatening dressed like this, but if I put my kufi¹¹ on and miswak¹² and walk through the airport anywhere, people look extra hard...”

(FG 18-40 Revert Male)

¹¹ Arabic for Hat

¹² Miswaak - twigs of certain trees that are used on a regular basis by Muslims for centuries (and all Prophets Peace upon Them) to maintain oral hygiene and gain the pleasure of Allah SWT. It is a "natural toothbrush." Not only does it provide spiritual benefits, but it is also beneficial to the everyday maintenance of one's mouth, gums, and teeth (<http://www.islam.tc/Miswaak/>)

Faith and Lifestyle:

It became apparent through the focus groups that people's journeys within their faith has lead them to develop life style choices, unique and different to other peoples. Both individual and interdependent lifestyles are essential aspects of participants local and national views.

"My faith is my life"

(FG 26-40 Women)

"...It helps us move forward or we would be lost...it gives you comfort and strengthens you as a person, and keeps me sane."

(FG 26-40 Women)

"Can't live without it"

(FG 18-40 Reverts Men)

"Every religion has people who centre their faith around their life, we are no different...it sets a boundary too."

(FG 18-40 Reverts Men)

"For me personally Islam shapes my life for example I would not work in a place if I cannot fulfill my Islamic duties, my prayers...I will look elsewhere for a job where I can both work and pray I see it as important aspect of my life"

(FG 18-40 Reverts Men)

Identity and Paranoia:

In the current political climate, local, national and international events have left individuals feeling fearful and paranoid. Some participants discussed the heightened tensions since July 7th. Some even dated this back to 9/11. Many felt ostracized by the communities they work and reside in, and for those who are experiencing a mental health crisis this paranoia and fear is magnified. These insecurities can be understood as responses to an increasingly Islamophobic¹³ society which demonises Muslim communities and which excludes diversity and complexity of identity within the Muslim community, tending to label all Muslims stereotypically. In an interesting way these perceptions that are thrust upon the participants has strengthened the formation of their Muslim identity and has enabled them to revisit their beliefs and values.

"I don't personally walk around with this paranoia but I think as a group the connotations attached to Muslims generally are very negative...and I think that is related to what is going on at the moment across the globe"

(FG 18-25 Women)

¹³ "Islamophobia" is a neologism referring to a fear, and accompanying hostility, towards the religion of Islam and its adherents, or by extension to predominantly Muslim cultures (<http://en.wikipedia.org/wiki/Islamophobia>)

“...Someone at work asked my name...he said I find it funny and some what ironic that this government employs the same people who are from the group of people who bomb the capital city in our country...”

(FG 18-25 Male)

“...I no longer feel comfortable getting on the train because everyone just looks”

(FG 26-40 Women)

“Yeah and that we’re always trying to fit in somewhere”

(F 18-25 Male)

“I feel if I have to remain on best behaviour always, a step out of line and people see me differently even if I’m out laughing, people look and think what are they laughing about, that’s how I feel”

(FG 18-25 Male)

“I mean that lady that was burnt in London simply because she was covered and that makes us question how can we go out, you know without being covered because we can’t cos that’s us...”

(FG 26-40 Women)

“...So you’re constantly covering your back it kind of creates a paranoia”

(FG 26-40 Women)

Individual Racism

We will discuss institutional racism later.

Underlying subjects’ responses to the questions in section one, the experience of racism lurked. Most participants had experienced some form of racism. In addition to personal experiences, they also discussed their experience of racism within mental health services, both individually and as a group.

“As a Muslim I feel I am not treated as well as others, this could be on a bus, with no reply to even my simplest thank you or please”

(FG 26-40 Men)

“Can you remember the guy that got shot by accident?...they can decide on anyone...just anyone because of the way that they are dressed...or because someone’s got a beard...that’s racism”

(FG 26-40 Women)

“Im a Muslim revert...but when I had an “episode” was given a curry...im not being disrespectful but I don’t eat curries, its not good for my ulcers...yet because you’re a Muslim, they assume you’ll eat curry”.

(FG 18-25 Men)

Community Denial

The only focus group to raise this theme was the 18-25 year old Muslim men. They commented on how difficult it was to breakdown the barriers in terms of the perceptions people had of individuals who had mental health problems, in particular peers from their own community. They felt that the Muslim community fails to engage in discussion or debates on issues of mental health, because it is frowned upon within the wider community. There was a lack of awareness which needs to be addressed.

“...Society has changed, we’ve got two or three generations now...most Pakistani elders if you go to see a psychotherapist you’re a goner...the community won’t look at you twice”

(FG 18-25 Male)

“... With the older generation if you tell them that you’ve got a mental health problem, all they say is ‘we’ll go to see pir¹⁴ sahib and get a taweez¹⁵ for you, doesn’t mean it is getting better, it might be getting worse the issues are still there.”

(FG 18-25 Male)

“In our community there’s this thing called baste, shame, when someone’s child’s got mental health problems the word is spread and it’s a big shame”

(FG 18-25 Male)

6.2 Section Three: Questions 4 and 5

Institutional Racism

The basic practical needs of individuals, such as Halal¹⁶ food, prayer facilities, direction of prayer, safe spaces for women and more choice of gender of keyworker are still recurring themes that participants highlighted as areas that are important to them and need addressing.

“With food, you are limited with halal food, you get small portion of food compared to other people who have no halal food.”

(FG 18-25 Men)

¹⁴ Pir is an Urdu term for Sheikh, meaning elder of tribe, a revered old man, or Islamic scholar.

¹⁵ Taweez is an amulet or charm containing inscriptions or verses from the Quran to protect oneself against evil and Jiins.

¹⁶ Lawful food in Islam according to Islamic law, Sharia.

...I can remember when I was admitted I told them that I felt possessed...there's a whole chapter on this in the Quran...but nothing I said made a difference...I was sectioned and remained there for six months".

(FG 26-40 Men)

However, the following segment indicates that although services may reach adequate standards as far as cultural competency is concerned, this alone is insufficient. This woman believes that her cultural difference means that she is treated less favourably than people from other groups.

"...I just plain and simply feel that all services that we receive are not equal, we are treated as second class citizens, we pay our taxes, we work here but due to the colour of our skin our faith and religious practices we are seen as strange...for me the basis need to change...they need to acknowledge that there are problems because that's when real change will take place"

(FG 26-40 Women)

This has important implications for the type of support that is on offer to Muslims.

Stigma

An overwhelming majority of participants discussed stigma within the context of services being culturally unaware of faith and religious beliefs of service users. Some participants described this as 'double jeopardy' which reinforces stigma through institutional racism, media coverage and Islamophobia. Therefore the state of being in distress brings its own stigma, coupled with this the stigma of being Muslim being perceived as being different adds to their alienation.

"I personally feel that we're categorised as mentally ill...when you get a little passionate about what you believe in you're seen as getting a bit crazy...like they see you as you've lost the plot"

(FG 18-25 Female)

"...To be constantly portrayed in the media the way we are and then on top of that have a mental health problem...I mean who could survive that?...and I'm sorry I do think as soon as you walk into a mental health service then you are dealing with this because that's how you are seen"

(FG 18-25 Male)

"It makes me feel angry...why am I being judged just because of what I'm wearing...why can't people give you a chance...it's frustrating...it's disempowering"

(FG 26-40 Female)

Language and Alternative forms of Support

Another theme which ran parallel across all seven focus groups was the use of language. Many participants felt comfortable in using alternative terminology which they found helped describe their experiences and express their emotions. Islamic terminology was used to describe alternative forms of healing and support. Participants also highlighted and discussed how medication would be their last resource.

“I would look into visiting a Mufti¹⁷ sahib... someone who could give me something out of the Qur’an”

(FG 18-25 Female)

“I would go to a Sheikh no doubt”

(FG 18-40 Reverts Male)

“I would love to have a personal Imam¹⁸”

(FG 26-40 Female)

“I will feel more comfortable to attend or see a Mufti or Maulvi¹⁹ that is regulated”

(FG 26-40 Male)

“Some GPs give you medication when they don’t even know what type of illness it is. I’d go somewhere where a person had alternative medication, such as a hakeem²⁰”

(FG 18-49 Reverts Male)

“So culturally aware organisation, with Mu’allima’s and Allims”

(FG 18-40 Reverts Female)

“I would set up a talawat room, salawat and dhikr for relaxation and contemplation”

(FG 26-40 Male)

¹⁷Mufti is an Islamic scholar who is an interpreter or expounder of Islamic law, Sharia.

¹⁸ Imam is an Arabic word meaning "Leader". The ruler of a country might be called the Imam.

¹⁹ Maulvi is the Urdu term for Imam.

²⁰ Hakeem is a practitioner of Tibb or eastern medicine.

Gender Specific Services

An aspect of culturally competent services is recognising that some individuals from BME communities would require safe spaces that are gender specific. The focus groups were an example of what can be achieved when the needs of the people are taken into account. This safe space enabled women participants to share views openly and freely even though they might have been challenging community norms.

“...Culturally aware organisations with Mu’allima’s you would have to have gender and age specific services”

(FG 26-40 Female)

“The issue of mehram²¹ is of great importance, I as a practicing woman would feel more comfortable in discussing my issues with a woman scholar rather than a man...”

(FG 18-40 Reverts Female)

“...See there are something’s that you just don’t go to your female doctor with...”

(FG 18-25 Male)

“Listen bro you know these dhikr classes we have you can’t expect women to come there, you need something like this for them separately”

(FG 18-40 Reverts Male)

Social Exclusion

Social exclusion was a recurrent theme throughout the focus groups and participants emphasized that since July 7th 2005 and September 11th, Muslims have felt the aftermath of being socially excluded by the communities they reside and work in. Participants mentioned how many of them became distrustful and began isolating themselves from other communities. Institutions were also seen as means of socially excluding individuals from the outside world by allowing patients limited time day release and visits.

“We have become withdrawn...because you become distrustful...distrusting people you become isolated from the wider community...you’re not sure how you feel with white people, work colleagues...you’re labelled...all the same”

(FG 18-40 Women Reverts)

²¹ Mehram Is an Arabic word denoting an escort of a woman who is travelling. The escort is usually male and to whom the lady travelling can not get married to i.e. father, brother, grandfather, uncle.

“Since September 11th society had slowly started to accept us and due to the atrocities of 7/7 every Muslim individual is seen as a terrorist...if any individual is not the same colour as them they are seen as a Muslim...so I always now think twice about travelling to London”

(FG 26-40 Male)

“Really disheartening and excluded, I feel sad because we are misunderstood”

(FG 26-40 Female)

“...I can remember walking...it was one corridor after another...it’s dead...if you aren’t depressed when you end up there you’ll be worse off...it slowly but surely kills you off...people are walking about in a state...it’s not normality”

(FG 18-26 Female)

6.3 Section Two: Question 3

This section describes how the participants understood any links between their personal and or political identity and their mental health. Also in this section groups discussed what they found helped them in times of crisis and what enabled and promoted their mental health and well being. Participants spoke of good support networks, how some informal structures aided their recovery and a majority of them spoke about how religious practice such as supplications from the Quran and Sunnah or Dhikr was fundamental to promoting good mental health, this is discussed in detail a little further in this section. Remarkably all participants’ spoke of how certain events, namely 7/7 and 9/11 had left them feeling isolated, fearful and disempowered which ultimately resulted in them disconnecting from the wider community. Many spoke of terrorism, the media coverage this received and the impact this has had on their mental health and well being.

One female participant summarised her feelings in the quote below:

“You know what I said earlier...about how we are seen as terrorists...the fact that we have become fearful...not safe has all impacted on our mental health...”

(FG 26-40 Female)

A few paragraphs down she continued to state:

“I’m sick of us being portrayed in a negative image...things have changed since 7/7...actually I would go before that and say things really changed since 9/11...How can we follow and practice our religion? All this affects us...”

(FG 26-40 Female)

In the 18-40 Reverts Male focus group this point was singled out up by another participant who stated that:

“The term mental illness is used to categorise us...them Muslims are off their head and crazy”

(FG Reverts 18-40 Male)

The same discussion took place in focus group 18-25 Muslim Females, where again participants highlighted the differences that are emerging in how Muslims are perceived within society.

“...It’s almost like there isn’t any balance in a Muslim’s life...there are variations in other religious groups but not Muslims...there’s an extreme on one end and another extreme at the other...I feel like a dangerous sort of thing...uncontrollable”

(FG 18-25 Female)

In this particular focus group participants discussed how they felt that they were left feeling disheartened and misunderstood.

“As a community we are just constantly apologising for something we didn’t do over and over again”

(FG 18-25 Female)

“I personally think that we’re seen as mentally ill...when you get a little bit passionate about what you believe in, you are seen as getting a bit crazy”

(FG 18-25 Female)

“I personally think that we are seen really heartless...and that’s all down to the media...’cos that’s all people think that were mad, bad and damn right crazy... it’s affected me really badly...”

(FG 18-25 Female)

Clearly the issue of terrorism was discussed as a major obstacle in terms of Muslim integration with wider society the impact of this on individuals’ mental health and well being but was also a concern felt by all sections of the community, regardless of gender, age and ethnicity. Amongst this discussion participants spoke of how they would console themselves through Supplications and Dhikr

“Basically my personal connection between me and my Lord...this keeps my head above water”

(FG Reverts 18-40 Male)

“But I think that’s where our faith kicks in and you console yourself through your prayer...dhikr”

(FG 18-25 Female)

“When I travel I do my dua for travelling, and that’s reassures my mind...that’s what I do all the time and I feel safe. So I do duas reciting certain Suras²² when I leave the house, this all makes me feel safe...”

(FG 18-25 Female)

“Moulana saab (imam) who listens to my problems and solves them through Islamic guidance, this satisfies my heart as explained to me from something relevant to me and what I can incorporate as a Muslim”

(FG 26-40 Males)

Semi-structured Interviews

Individuals who did not fully participate in the focus group scenario were afforded the opportunity to partake in one to one semi structured interviews. A total of twelve semi structured interviews were which were equally spilt along gender lines were held. These interviews provided a safe space for people to freely express views with out the fear of being singled out.

To illustrate the nature and depth of the one to one interviews we highlight two examples which reflect and bring out the themes similar to those from the focus groups. The names of the individuals have been changed to protect their identity.

6.4 Case study one

Hafiz is Pakistani Muslim male who is 27 years old.

He was referred to Sharing Voices through networks and partnerships we have established. He has been involved with mental health services for over ten years. On first contact he was not comfortable with any of the community development workers and researchers. He believed they were undercover doctors or reporters and were here to increase his medication. Over a few weeks and regular visits Hafiz established a relationship of trust with one of the workers and began discussing his issues and how he felt no one understood what he was going through.

We discussed factors that contributed towards his mental health such as family pressures and expectations, spiritual struggle, taweez, black magic and Jinn. Hafiz felt comfortable discussing these issues as he believed the community development worker was able to relate to many of the issues discussed. He began to develop his own coping strategies and pathways to wellbeing e.g. reducing smoking. If he was unable to sleep at night he spent time in prayer, reading the Quran and meditating, which helped him to relax and enabled him to get to sleep.

As a result, Hafiz stepped out of his home on his own accord to visit his brother after a number of years.

²² Surah is a chapter of the Quran.

He became more actively involved with Sharing Voices, and regularly participated in activities with other young men (pool and fitness group).

He indicated how he felt let down by services, that all they offered was medication and someone to visit him once a month, and how he was able to express how he felt through his discussions and group work. He valued his beliefs and felt that if it was not for a Muslim male worker who understood his issues, he would probably have remained socially excluded.

6.5 Case study two

Sarah is an Indian Muslim female who is 34 years old.

Sarah was diagnosed with depression at the age of 26 by her GP. Her problems started in 1998. She woke up to follow her normal daily routine when she suddenly felt apprehensive; she spoke to her partner who advised her to speak to her GP.

She made numerous appointments and described her symptoms, which included feeling cold and unable to sleep at night. She was prescribed sleeping tablets and advised to rest and seek counselling.

After a few days she began to hear voices. She told her husband, who reassured her that it was her thoughts and not to worry. Then she began to believe that belongings in the house were being moved, and she described the presence of another being.

Sarah felt her GP was not the safest place to discuss these issues as she didn't want to rely solely upon medication. She discussed the issues with her family and her husband. Her family got in touch with a Sheikh whom they trusted, and who could provide traditional and spiritual knowledge from within an Islamic framework. The sheikh organised meetings with Sarah and her family. He advised of supplications for her to read and provided her with a Taweez (amulet with inscriptions and verses from the Quran).

She felt comfortable with this advice and support as it helped her to understand what was happening, and to build on her inner strength through prayers. The information was both relevant in terms of tradition and also her faith beliefs, but within a confidential manner.

Over time Sarah felt lethargic but in control of her own mind and body once again.

She is now a working mother of two and understands the concept of spirituality and Jinns. This has helped Sarah make sense of her experiences. When Sarah feels overwhelmed by voices she knows what supplications to read or who to see. She is happy that she did not approach services as she feels they would never have been able to understand what was going on in her life at the time.

Sarah did not solely rely on medication and sought after help from someone within her community with whom she was able to build a relationship of trust and understanding. This person was able to help her articulate her understanding of mental health. She believed that if she had approached the GP she would not have been

offered the same advice because the doctor would not have shared the same understanding.

7. Discussion

In the past mental health services have responded to cultural difference in relatively superficial ways, such as attending to diet and language. Although these are important, it is clear from the responses of the subjects in this study that they are insufficient. Shifting the balance of power is an attempt to develop user defined services, which are congruent with people's faith and values both historically and currently there has been a resistance within services to change and become more accessible. This practice informed by Eurocentric views of psychiatry, lack cultural competency reinforces racist views that impinge on people's ability to recover.

The Macpherson Report²³ into the racist murder of black teenager Stephen Lawrence has drawn attention to the importance of institutional racism in all areas of public life, including health. Macpherson defined institutional racism broadly in terms of institutional policies and practices that do not overtly discriminate, but which result in different outcomes and experiences for people from BME communities when compared with members of the White community. Kwame McKenzie²⁴ writing in the *British Medical Journal* points out that the issue of health inequalities related to institutional racism is a feature of the ideology in biomedicine that downplays the importance of cultural difference. Institutional racism is pervasive. It is implicit in the training of all staff in the NHS, which relies heavily on the disease concepts of Western psychiatry, which override the deeply held beliefs and traditions of people from non-Western cultures that have deep meaning for them.

Therefore the state of being in distress brings its own stigma, coupled with this the stigma of being Muslim being perceived as being different adds to their alienation.

Services are 'competent' when the leadership and managers send clear messages about developing equity of experience and service outcomes for Muslim and BME service users. Developing recruitment, training and development policies that promote this is central to continued development of staff and improvement of services. In addition consideration needs to be given to both the practical day to day needs of people involved in the system and also their spiritual and identity needs. The development of culturally competent services is essential if there is to be equity and equality of service outcome for BME communities.

Islamic terminology was used to describe alternative forms of healing and support. Participants also highlighted and discussed how medication would be their last resource.

This takes us way beyond limited notions of language, couched in narrow linguistic terms, as for example happens when we discuss the importance of interpreters who can translate for the psychiatrist or psychiatric nurse. The question at issue here is what is being translated? It's only the language of biomedicine that needs to be

²³ HMSO (1999) The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny. Available at <http://www.archive.official-documents.co.uk/document/cm42/4262/4262.htm>

²⁴ McKenzie, K. (1999) Something borrowed from the blues? We can use the Lawrence inquiry findings to help eradicate racial discrimination in the NHS. *British Medical Journal*. 318: 616 – 617.

translated because, culturally, its concepts and idioms are alien. Islamic forms of healing and support require no translation because the concepts and idiom are in Arabic or in the Islamic languages. Language and concepts are interwoven into the cultural fabric of Islam and require no translation.

7.1 Reflection

“...People going through mental health know what they are talking about more than anyone else. I believe they have more experience of what’s going on around them. I learnt a lot from this one individual at the training, her personal experiences that no one else could put forward or understand....should be given a leading role or a platform where they can discuss their issues with services”

Sami Babiker (*Community researcher*)

Towards the final stages of the project, whilst writing up the themes the researchers highlighted the need for the NHS to change its framework and not solely to rely upon and work with the medical model. This was also illustrated via the focus groups and semi-structured interviews which again reaffirmed the need for choice and for this to be made available at first point of contact and not an add-on.

There is a wealth of untapped expertise within the community that is being wasted for example: it would be cost effective for the NHS to work alongside or to employ individuals that are alims or muftis that work within an Islamic framework and who also have knowledge on mental health. Throughout the project between 6-10 participants requested to meet with Alims and muftis, as it was felt this would help aid their recovery where they felt everything else had failed. Whilst conducting this research and working alongside local Mufti’s and Sheikhs the community researchers learnt that there was vast amounts of Islamic knowledge that exists, such as supplications and advise that can aid an individual’s recovery.

The project has equipped the researchers with skills such as listening, supporting, building individuals confidence and self esteem while being non-judgemental, but above all to believe in someone’s ability and help them achieve their goal whatever that maybe i.e. reduction of medication, active roles within their family and community and allow individuals to access daytime activities.

Some participants became aware of Sharing Voices and that there is alternative support available. This was positive as many individuals felt that they did not have to primarily rely on services in the future.

The researchers and community development workers feel that a weakness within the project was the failure to engage individuals with disabilities, both within the focus groups and semi-structured interviews as it would have been beneficial for them to express their voice but also would have added another dimension to the project. During the final focus group the researchers highlighted the need for a separate focus group to incorporate individuals with dual-diagnosis and in this discussion page we strongly suggest that this particular research be taken on board.

There were only two researchers involved in presentations and chairing steering group meetings, upon reflecting on this others highlighted that they would like to pursue or

would be happy to partake in further practise or training in mental health, presentations and chairing meetings.

The team of researchers and workers expressed commitment to the project and would like to see the report being implemented within the policy and/or practises of the primary services, NHS and PCT's. It was hoped by the research team that a year long project and the wealth of information obtained, the time and effort they have undergone not go to waste and for this to become "another project". Finally the researchers have expressed that they would like to remain as volunteers and learn more about the ethos and framework that Sharing Voices works with.

Overall what was unanimous was the belief and passion in which the research was conducted and carried out in order to improve services for the betterment of one particular community, however findings show the importance of faith based approaches which could result in the betterment for other community and faith groups.

8. Recommendations

Many of the following recommendations reflect the ‘choice’ and ‘modernising’ agenda of the NHS, promote social inclusion and are in keeping with the key characteristics identified in Delivering Race Equality in terms of the three key building blocks. In view of the fact that there are recognised health inequalities particularly amongst BME mental health services users, of which the Muslim community is significant, the authors of this report suggest that these recommendations should be implemented as an integral part of improving and developing the quality of outcome and experience as well as choice options for Muslim mental health service users. The development of the local Focus Implementation Site will play a key role in shaping services and therefore we would hope that these recommendation be incorporated into the local FIS developments. The following recommendations are drawn from the participants’ comments and should shape any attempts to develop a choice framework for Muslim service users.

In addition, the general principles underlying these recommendations have broader appeal, and the potential to improve the situation for non-Muslims too. Many of these recommendations have been implemented on a small scale within the voluntary and charitable sector (SVB) and now need mainstreaming with sustained funding and partnership between statutory and voluntary sector agencies.

1. Gender specific safe spaces and community-based Alims:

Evidence

Gender Specific

“Culturally aware organisations with Mualimas or Alims on board I personally would think that people would really benefit from that”

(FG 26-40 Female)

“I would employ a religious person with sound knowledge and education on how to live as a model father, son, brother, citizen as these are the issues that can affect us also”

(FG 26-40 Male)

“It would help to have a mufti or sheik or others such as hakims that can give a different view point and advise us from their knowledge of the Islamic perspective and how to use that in today’s society in a practical way”.

(FG 18-25 Male)

“.... Some women don’t want to talk to a man about certain issues and problems so that needs to be considered also”

(FG 26-40 Women)

Safe spaces

“To hold discussion groups like this regularly where Muslims can help one and another and discuss the issues.... And how to deal with them”

(FG 26-40 Male)

“It’s good saying but the thing is the maulvis are known by all our areas. It is better there was a safe space if we could meet or see them”

(FG 18-25 Male)

“I would set up a talawat room, salawaat and dhikr for relaxation and contemplation”.

(FG 26-40 Male)

Recommendations

1. Resources should be made available to employ Alims/Alimas (male and female scholars) based within the community, and who would work alongside statutory and voluntary organisations. For discussion on Alims please refer to rationale below and to glossary.

2. Safe spaces in both statutory services and in the community should be developed and promoted. This involves creation of user defined activities and or self help groups based upon the needs and experiences of people. This in a statutory mental health setting refers to engagement with groups of people stimulating discussion, debate, trust and confidence to allow people to influence and have a say in their recovery as opposed to a system where people receive coercive treatments and people are passive recipients of medical interventions. This involves developing ‘in reach’ facilities where voluntary agencies and community development workers can come onto the ward and engage people in processes aimed at developing their capacity and involvement in their own recovery. Self help groups are supported and developed with the intention of giving ownership to people in distress to direct their own activities. Safe spaces need to be tailored to reflect gender, cultural and religious identity and where ever possible to stimulate diverse membership of groups as has been the case of SVB.

3. Development of and access to information and advice facilities that are targeted at people living with mental distress and their families. Evidence suggests that the best place to develop this provision is within the voluntary sector with strong involvement and partnerships with the statutory sector.

Rationale

The role of the Alim / scholar and sheikh within the Muslim community is to provide religious guidance and make relevant Islamic teachings to people’s

experience where ever they may be. The Muslim Alim contextualises key Islamic principles and offers guidance and solutions and or advice if asked about issues that are affecting people's lives. Within the context of providing services to Muslim mental health service users interventions can be developed which are meaningful to Muslim users that are congruent and in keeping with a persons own cultural norms and views. Due to the interdependent nature of Muslim families occasionally there are situations where there is whole family crisis. As such solutions can be developed that are multifaceted and are targeted at key underlying crisis indicators such as marriage, domestic violence, relationships etc.

The above comments, contained in the evidence section, highlight the need and desire of Muslim service users to access support that is meaningful, is faith based and which addresses key issues around spirituality enabling the person to reconnect in a real, empowering and sustainable manner.

Throughout the research process a significant number of participants accessed a local mufti and or sheik to provide a religious or spiritual framework from which participants could make informed choices, and to make sense of their experiences. This is important because when in crisis, and everything else has failed, people's values and beliefs are all that remain. However, participants have indicated that far from being a last resort people want and need Alims/ mufti/hakims, use of safe spaces and or sheikhs to be a central aspect of recovery pathways. Providing help that enables the person to make sense of their experiences within a faith tradition such as Islam (or for that matter, any system of belief shared with others) is for many the first step on the road to recovery. Employing gender specific Alims/Alimas is a vital recommendation and is a key component of a culturally competent service.

A local example of safe spaces in the community has been the development a Dhikr group which was set up by one of the persons involved in the research. This pilot scheme has now been running for three months and has now reached a regular attendance of between 15 to 23 people every week. The group is held in the evenings which is accessible to individuals 8pm to 10pm. This can quite easily be replicated and developed in other areas. One of the participants who came from sheltered accommodation provided by the Care Trust was prevented from participating fully due evening closing times of the institution; flexibility in this regard would be extremely useful.

Expected Outcome

This recommendation will result in:

1. Increased use of early interventions and promoting earlier access to support.
2. Provide pathways that are non medicalised and congruent with people's beliefs, increase earlier access, support people's value framework and offer choice as well promoting quicker recovery times.

3. Reduce numbers of BME people using specialist mental health services.
4. They will also increase the capacity of people living with mental distress to cope with their experiences and promote recovery.

Development Responsibility

The responsibility for taking this agenda forward lies with commissioners of services, service leads that cut across primary and secondary care and the voluntary sector for housing Alims. The development of safe spaces within services need to be addressed by lead managers including estate management, working closely with the voluntary sector for incorporating culturally competent design requirements in renovation and ‘new build’ development.

1. Commissioners should resource community organisations that are best placed to work with and employ Alims / Alimas and be housed within a community development setting. This interchange and praxis of ideas including community development, faith based interventions and capacity building of individual and families will result and has resulted in a dynamic transforming recovery process which for Muslim service users is what they have articulated the need for.

2. Safe spaces are necessary and should be provided both in statutory services (e.g. inpatient units) and outside services in the community. Developing partnerships between statutory and voluntary sector agencies need to be facilitated and sustained. Within this power dynamic third sector organisations need to be supported to retain a critical perspective that challenges and enables statutory provides. Community ownership, validation and consent need to be central themes of partnerships developed.

2. Choice:

A key element of government health policy is ‘choice’. However in mental health services choice is restricted to Western models of illness, therapy and treatment. The central theme of these recommendations is that commissioners must provide a menu of choices for Muslim people in distress. Choice must be available both within statutory services and the voluntary sector. And indeed the authors would argue that sustainable change in the experience and health outcomes of Muslim mental health services users is only achieved when people living with distress are placed at the heart of recovery process. A process which they direct and that is supported by an alliance of voluntary sector community development and statutory interventions. It is self evident that this process can not happen without the absence of a long term commitment to sustainable funding for BME mental health organisations and perspectives.

Offering choice to Muslim people in Bradford includes the following:

Hakims:

Evidence

“...it would help to have others such as hakims who can give a different view point and advise us from their perspective”

(FG 18-35 Male)

“...the services should employ someone who deals with herbal Islamic medicines”

(FG 26-40 Women)

Faith-based Resources

Evidence

“I would set up a talawat room, salawaat and dhikr for relaxation and contemplation”.

(FG 26-40 Male)

Within statutory services both faith and cultural resources need to be in place so that people can develop. These include having available resources such as prayer mats, copies of Qurans, separate women’s prayer rooms, direction of Mecca placed in rooms.

Recommendation

1. Commissioners should make resources available to employ Hakims. These could be accessed through community groups, but made widely available to people in the community, primary and secondary care.

2. Service providers should ensure that there are faith-based resources within residential and other statutory service provision. Faith based resource could include space for pray (including gender specific), ablution facilities, prayer rugs, prayer beads, resource and information library as well as audio visual materials.

Rationale

Much of the rationale behind this recommendation has been discussed under the recommendation for Alim sited above and should be central to recovery pathways developed within the district and not seen as periphery.

Within the research and discussion around Islam and mental health the use of holistic perspectives was discussed and advocated for by participants. Hakims (plural) are practitioners of complementary herbal medicine and therefore are central to any holistic care package. Within the Asian community the use of hakims and or traditional practitioners of Ayurvedic medicine are used as a

first point of call as they are often affordable and are individually tailored to the needs of people. Furthermore traditional medicine which is individualised has very little side effects and also there are many examples of the Prophet Muhammad (SAW) recommending certain foods for their therapeutic qualities e.g. honey, olives, figs, dates, ginger etc. Thus food is central to Muslim spirituality and appeals to many in the Muslim community.

The development and facilitation of these resources brings about the development of services that are demanded and which are culturally sensitive. The evidence provided above is clear and concise.

Development Responsibility

Responsibility for carrying these recommendation lies with commissioners, service managers within the PCT, Bradford Care trust and the voluntary sector. New resources have to be made available to ensure choice is central to the service experience of Muslim people.

Expected Outcomes

Adopting a varied choice approach will lead to the development of:-

- Less coercive pathways of mental health recovery.
- Increase of BME participation in non medical interventions.
- Will have a knock affect on recovery times.
- Save money on medication and acute care.
- Develop community and individual capacity to cope with distress.
- Reduce stigma of distress.
- Appropriate responsive services and culturally responses.
- Improved culturally competent services.

3. Cultural Competency and Good Practice in Services

Evidence

“...for example I wouldn't work in a place if I cannot fulfil my Islamic duties i.e. my prayers”

(FG 18-40 convert

Males)

Recommendation

The development of cultural competency within the framework of mental health provisions both at a strategic and coal face level are of primary concern. Strategically services need to accommodate and reflect the fact that we live in a diverse community and as such notions of health and its promotion are woven into the cultural, linguistic, spiritual, social and religious fabric of communities. Health recovery is therefore tide into these very same notions so

examples of smoking cessation programmes which involve giving dates out during Ramadan (fasting month) or the 'Smile with the Prophet' project which promotes dental health are example of best practice which are already proving successful within the Muslim population of the Bradford City tPCT area.

Cultural competency at a strategic level means an acknowledgement of health recovery perspectives that are not rooted in western models of health and recovery. It also involves a realignment of service organisation, management and delivery. This in turn necessitates the development of:

- Development of a culturally diverse and competent workforce. A work force that recognises BME cultural and religious perspectives and has clear pathways for induction, supervision, and progression.
- Development of services that are located within the community are non- stigmatising, confidential, that promote democracy and are person centred.
- Developing and supporting strong partnerships between the statutory and voluntary sector. And creating space for services to be housed and managed within the voluntary sector.
- Development of interpreting and language facilities that are robust enough to convey the needs of patients and which maintain respect and dignity of users.
- Developing training that brings into focus diversity in the context of perception and notions of health, recovery, gender and religious affiliation and what this means for people living in mental distress. Training around cultural competency needs to be continually developed and maintained and should be developed by promoting the notion of promoting better health. Staff need to own cultural competency in this context. Cultural competency and diversity should not been seen as a way to get at workers but as a way to support people in distress.
- Developing robust performance management systems that regularly check diversity issues and outcome experience of Muslim people. This could involve auditing how often the culture and religion of a person is brought up in team meetings, the assessment process as well as availability and monitoring of usage within a facility.
- Developing services that are gender specific
- Educational programmes for undergraduates and postgraduates, that enable staff to recognise the importance of their own values attitudes and beliefs in working with people from different cultures.

- Enabling staff to become familiar with different faiths and cultures and having the confidence to ask people how they would like to be addressed and treated in essence giving people dignity and respect.

Good Practice Models

Developing and support good practice models both within statutory provision, the voluntary sector and wider mental health economy needs to be identified and supported especially where practice models are appropriate and responsive, provide information to people and engage the community in a meaningful manner.

Rationale

What has been amply demonstrated through participants involved in the research as been the fact that they want to see the development of services that take into account their faith and spirituality as central components to promoting mental health, well being. Simply dismissing people's faith traditions as being invalid can cause further distress. For Muslim women, being left alone with men can aggravate distress further because keeping their personal space private and away from men is an essential aspect of their devotional life.

Furthermore a good practice framework needs to promote a positive personal identity built on the person's faith tradition. By developing meaningful interventions such as training, education, social and recreational activities that are congruent with their faith and spirituality will promote and aid recovery. Muslim communities on the whole live interdependent lives and therefore the good practice framework needs to take into account the challenges of working with extended families and how they tie into promoting well being of individuals.

Within this good practice model the above recommendations of creating safe spaces and employing community chaplaincy workers is also essential.

Developing staff competencies that equip them with the tools to engage people from different faith and cultural traditions, and their spiritual needs, is a crucial component of the training and continuing professional development of *all* staff who work in mental health services. It is argued that this training is best focussed on staff values and attitudes. Enabling staff to negotiate the complex interplay of diversity visa vi their own values that may be completely at odds with service users and supporting people.

In addition, developing work practices that accommodate the needs of Muslim staff to maintain their religious practices is central to employing and retaining staff from the Muslim community. For example devising work patterns that accommodate prayer and fast opening times would improve morale.

Expected outcome

- Increased development and confidence in services the flip side is fear is reduced of services a central focus of DRE.
- Increased diversity within workforce which is again a key component of DRE.
- Increased quantitative and qualitative information from which services can bench mark progress as well as develop services further.
- Increased recognition and development of gender safe spaces.
- Increased partnerships between voluntary and statutory and educational establishment. For example the BDCT and the PCTs need to be closely linked into and have partnerships with the development of university courses for mental health nurses and other professionals.
- Better Less coercive pathways of mental health recovery.
- Increase of BME participation in non medical interventions.
- Will have a knock affect on recovery times.
- Develop community and individual capacity to cope with distress.
- Reduce stigma of distress.
- Appropriate responsive services and culturally responses.
- Improved culturally competent services.

Development responsibility

All commissioners and service leads in mental health and local authority, with a strong emphasis on voluntary sector involvement, facilitation and sustainability.

4. Employing culturally competent family support:

Evidence

“It’s like when I went home they called my family and ask how I’m doing, if it is not as they expect or even one thing wrong, that’s it they’ll have me back in. why can’t they discuss it with my family and make them understand and help together”.

(FG 18-25 Male)

“... My problems were family related but I wasn’t heard on this and was sectioned on ward 3, coz I was told I was getting worse”

(FG 26-40 Male)

“A happy mum means happy children, children tend to be more confident if they have a strong and confident mum because children feed off the vibes a mum gives, so if mum is suffering a mental illness then the family is suffering too, where is the support.”

(FG 26-40 women)

Recommendation

To employ a series of family support workers who would work to develop family centred services that promote family well-being and enable families to cope with mental health crisis in a relative, partner, parent and or sibling.

Rationale

The distress of individuals is heightened due to lack of mental health awareness within families. Developing one to one support with families to work around issues that individuals are experiencing would help to reduce institutionalisation and medical interventions. Lack of awareness reduces the involvement of families in looking at or identifying causes of distress e.g. forced marriage etc. Family support workers will have access to and links with a variety of other support agencies and could refer families for support and help.

In addition distress within family members has impact on children, siblings and parents. Personal examples and testimonies of individuals suggest that family life is placed into crisis when a member may exhibit distress behaviour. As such mediation and reconciliation are important tools to alleviate distress. Furthermore family support worker could work to support individuals and families through a synergy of religious, cultural and community development treatments and interventions. Family support workers with working jointly with Alims, Hakims, CDW's and family support workers could create and provide a comprehensive service that reduces people reliance on drug treatments and need for hospitalisation.

Expected Outcome

This approach will enable development of holistic services that address core indicators of stress.

Improve mental health awareness within families

Provide information and support the development of coping strategies that would promote family and individual well-being. This approach could lead to better success rates and help reduce the rates of re-admission.

The family support worker could also feed back into services and enable nurses, psychologists and psychiatrists to better understand and contextualise people they are seeing.

Expected outcomes also link into those already identified above.

Development Responsibility

Responsibility lies with primary and secondary care leads.

5. Governance and Quality/Training

The development of training packages to mental health professional especially at a primary care level e.g. GPs is vital to developing more inclusive and holistic strategies to deal with mental distress. Creating cultural understandings of mental distress, availability of complementary therapies and use of Hakims and Alims would enable to provision of person centred care.

Recommendation

To provide and develop bespoke training packages for staff working within statutory and third sector organisations. This approach needs to be developed in partnership with voluntary sector organisations who have expertise in working with BME communities and are culturally competent themselves.

It may be advantageous to support voluntary organisations by contracting them to deliver training thus creating alternative income streams for organisation which can be reinvested in provision of Community Development worker roles.

Expected Outcome

- Increased staff awareness and thus promoting improved health outcomes for people living with mental distress.
- Improved information enabling staff and commissioners to respond to needs of people. Thus enabling development of appropriate and responsive services.
- Developing a culturally competent workforce.

6. Strategic Planning and Implementation:

Recommendation

This report and its recommendations be included in the FIS action plan which ought and hopefully will cut across all agencies that are interested in enabling people living in mental distress to recover.

The FIS in essence is driving home the essential message of this report which is about developing appropriate and responsive services from the perspective of the user. It also takes a strategic overview and has the potential to create synergistic and sustainable partnerships across disciplines, including the voluntary sector. The FIS has been recently launched in Bradford and

therefore this report is timely and can inform the development of the FIS plan of action.

Rationale

These recommendations cut across health service boundaries. They have implications for commissioners and practitioners, Trusts and PCTs, primary and secondary care. In addition, many of these recommendations tie in directly with the work of the Focussed Implementation Site.

The above recommendations are entirely congruent with the views expressed by the participants involved in this research indeed this report has been circulated to all participants.

9. Glossary of terms

Tasauwuf: Is a branch of Islamic knowledge which focuses on the spiritual development of the Muslim. In Arabic the word for wool is *suf* and thus, those who wore it became known as the Sufis. Another possible derivation of the word comes from the root word *safa*, which means "to clean." Because the scholars of Tasauwuf focused on cleansing the heart, they later became known as the Sufis

Sufism: Is interchangeable with Tasauwuf/ Ilm Al Nafs the science "He who practices Sufism without learning Sacred Law corrupts his faith, while he who leans Sacred Law without practicing Sufism corrupts himself. Only he who combines the two proves true." (*Iqaz al-Himam fi Sharh al-Hikam*, 5-6 from *The Reliance of the Traveller*, w9.3, 862)

Muslim: Is a follower of the Islamic faith

Islam: Is the Name of the way of life revealed to the prophet Muhammad by Allah. Islam has at its core the Quran, the Sunnah of the Prophet Muhammad, His early Companions and legal president and scholarly consensus within the body of knowledge derived from the two primary sources.

Deen: Literally a way of life

Quran: The Eternal Revealed word of Allah sent to Prophet Muhammad over a period of 23 years. The ordering of its chapter and verse was instructed by the prophet Muhammad. A person who knows the Quran by memorisation is known as a Hafiz. There are many millions of people who have memorised the Quran in the world today.

Allah: From the point of view of traditional Islamic theology, Allāh is the most precious name of God because it is not a descriptive name like other ninety-nine names of God, but the name of God's own presence. Muslims believe that the name of Allah had existed before the time of Adam. It is the same God worshipped by Adam, Noah, Abraham, Moses, Jesus, Muhammad and other prophets of Islam. In Islam, there is only one God and Muhammad is the last messenger.

The emphasis in Islamic culture on reciting the Qur'an in Arabic has resulted in Allāh often being used by Muslims world-wide as the word for God, regardless of their native language. Out of 114 Suras in the Qur'an, 113 begin with the Basmala ("Bismi 'llāhi 'r-rahmāni 'r-rahīm") which means "In the name of God, the most kind, the most merciful". Muslims, when referring to the name, often add the words "Subhanahu wa Ta'ala" after it, meaning "Glorified and Exalted is He" as a sign of reverence, or "Azza wa Jalla". The entire religion of Islam is based on the idea of getting closer to God. Although commonly referred to as a "He", God is considered genderless, but there is no neuter gender to express this in the Arabic language.

Prophet Muhammad: Muhammad (c. 570–632) (meaning the most praised) transliterated into English in a variety of ways, most commonly Mohammed, is believed by Muslims to be God's final prophet sent to guide all of mankind with the message of Islam. He is referred to as "The Prophet" or "The Messenger" within the

faith. According to traditional Muslim biographers, he was born c. 570 in Mecca (Makkah) and died on June 8, 632 in Medina (Madinah). Both Mecca and Medina are cities in the Hejaz region of present day Saudi Arabia. The name Muhammad means "the praised one" in Arabic.

Salah: Salat (also known as "salah", "solat", "solah" and several other spellings) refers to the five daily ritual prayers that Muslims offer to Allah (God). It is a pillar of the Five Pillars of Islam in Sunni Islam, and one of the ten Branches of Religion in Shi'a Islam. As such, it is compulsory (fard) upon every Muslim. It is quite commonly known as "namaaz" in south Asian languages such as Urdu and non south Asian languages such as Persian.

The salah must be performed in the Arabic language even if the person neither speaks nor understands Arabic (although the dua afterwards need not be in Arabic). The prayers are to be recited by heart, although beginners may use written aids. The person performing salah is referred to as a musallee.

All salah should be conducted within their waqt (prescribed time) and with the appropriate numbers of raka'ah. While they may be prayed at any point within the waqt, it is considered best to pray them exactly at the beginning of their periods, when the call to prayer (adhan) announces the time of prayer. When far from a mosque, the time can be inferred from the position of the sun in the sky.

The word 'salat' is from the root Saad-Lam-Waw and has the following meanings): prayer, supplication, petition, oration, eulogy, benediction, commendation, blessing, honour, magnify, bring forth, follow closely, walk/follow behind closely, to remain attached, to contact or to be in contact. Its core underlying meaning relevant to all its usage in the Qur'an is to go/turn towards, as mentioned in Qur'an 75:31-2. In Islam, praying 'salah' is the most compulsory act, after the declaration of faith, the shahadah.

Sawm: Is an Arabic word for fasting regulated by the Islamic jurisprudence. It can be done for different reasons and at different times, but it is primarily done during the Islamic holy month of Ramadan. It is done because of the mandate in the Qur'an.

Dhikr: in Arabic ("pronouncement", "invocation" or "remembrance") is the remembrance of God commanded in the Qur'an for all Muslims. To engage in dhikr is to have awareness of God according to Islam. Dhikr as a devotional act includes the repetition of divine names, supplications and aphorisms from hadith literature, and sections of the Qur'an. More generally, any activity in which the Muslim maintains awareness of God is considered dhikr. Dhikr is also spelled zikr based on its pronunciation in "Turkish", "Persian", and "Urdu".

The Sufi orders engage in ritualized dhikr ceremonies. Each order or lineage within an order has one or more forms for group dhikr, the liturgy of which may include recitation, singing, instrumental music, dance, costumes, incense, meditation, ecstasy, and trance. (Touma 1996, p.162). Dhikr in a group is most often done on Thursday and/or Sunday nights as part of the institutional practice of the orders.

A group dhikr ceremony in Arabic countries is usually called the hadrah ("presence", referring not to God's presence but to that of the spirit of the Prophet Muhammad and

to the awareness of each participant). The hadrah marks the climax of the Sufi's gathering regardless of any teaching or formal structure. Musically this structure includes several secular Arab genres and can last for hours. (ibid, p.165)

The hadrah section consists of the ostinato-like repetition of the name of God over which the soloist performs a richly ornamented song. Often the climax is reached through cries of "Allah! Allah!" or "hu hu" ("He! He!"), with the participants bending forward while exhaling and stand straight while inhaling. The articulation of the name of God progresses as follows, with upward beams indicating inhalation and downward beams indicating exhalation:

PBUH: Peace be upon him is the English abbreviation of the mean of ; *salla Allahu alayhi wa sallam*, also transliterated as *sallallahu aleyhi wasallam*) is a phrase that Muslims often say after mentioning the name of the Islamic prophet Muhammad. An alternative translation is "May God blesses him and grant him peace." In Arabic, these greetings are called *salawat*.

For the other prophets and Islamic angels, a more abbreviated form with the same meaning, *alayhi is-salaam* is often used. This blessing is used by Shia Muslims after mentioning Ali ibn Abi Talib or one of the imams they believe followed Ali. It is seen as a mark of respect and is related to the Islamic concept of *dhikr* ("remembrance"). In English, it is generally abbreviated as PBUH, SAW or saas.

Hadith: Are traditions relating to the sayings and doings of Prophet Muhammad. Hadith collections are regarded as important tools for determining the Sunnah, or Muslim way of life, by all traditional schools of jurisprudence.

Muslim scholars classify Hadith relating to Muhammad as follows:

- What Muhammad said (*qawl*)
- What Muhammad did (*fi'l*)
- What Muhammad approved (*taqrir*) in others' actions.

There are also Hadith relating to the sayings and doings of the companions, but they may not have the same weight as those about Muhammad.

For the Muslim scholar, Hadith have a special status citing sura Al-A'raf 157: Those who follow the messenger, the unlettered Prophet, whom they find mentioned in their own (scriptures),- in the Law and the Gospel;- for he commands them what is just and forbids them what is evil; he allows them as lawful what is good (and pure) and prohibits them from what is bad (and impure); He releases them from their heavy burdens and from the yokes that are upon them. So it is those who believe in him, honour him, help him, and follow the light which is sent down with him,- it is they who will prosper. (Yusuf Ali translation)

Jinn: Muslims believe that jinn are real beings. The jinn are said to be creatures with free will, made of smokeless fire by God, much in the same way humans were made of clay. In the Qur'an, the jinn are frequently mentioned and Sura 72 of the Qur'an named Al-Jinn is entirely about them. In fact, the prophet Muhammad was said to have been sent as a prophet to both "humanity and the jinn."

The jinn have communities much like human societies, they eat, marry, die etc. They are invisible to humans, but they can see humans. Sometimes they accidentally or deliberately come into view or into contact with humans.

Jinn are beings much like humans, possessing the ability to be good and bad. They have the power to transform into other animals and humans, and they are known to prefer the form of a snake. It is also known that they eat bones and their animals eat droppings, that is why it is forbidden to perform Istinja (washing) with those items. Jinns also have the power to possess humans, have much greater strength than them, and live much longer lives. In fact, according to some Hadith, the great-grandson of Iblis, or the Devil (who was born before mankind), converted to Islam during the time of Muhammad, so he must have been thousands of years old. According to the majority of Islamic scholars, clear evidence exists in the Qur'an that the Devil was not an angel (as thought by Christians), but a jinn, citing the Quranic verse "And when We said to the angels: 'Prostrate yourselves unto Adam.' So they prostrated themselves except Iblis (The Devil). He was one of the jinn..." Surat Al-Kahf, 18:50. According to Islam, angels are different physical beings, and unlike the fiery nature of jinn, they are beings of goodness and cannot choose to disobey God, nor do they possess the ability to do evil.

In Islam-associated mythology, the jinn were said to be controllable by magically binding them to objects, as Suleiman (Solomon) most famously did; the Spirit of the Lamp in the Sufi story of Aladdin was such a jinni, bound to an oil lamp.

In the Qur'an, Suleiman had members of his army belonging to the race of jinn. Suleiman had the ability to communicate with all creatures, thus he could communicate with the jinn as well.

Evil beings from among the Jinn are roughly equivalent to the demons of Christian lore. In mythology, jinn have the ability to possess human beings, both in the sense that they persuade humans to perform actions, and like the Christian perception of demonic possession.

Mufti: A Mufti is an Islamic scholar who is an interpreter or expounder of Islamic law (Sharia), capable of issuing fataawa (plural of "*fatwa*").

Imam: Is an Arabic word meaning "Leader". The ruler of a country might be called the Imam, for example. However, the capitalized term or *The Imam* has important connotations in the Islamic tradition especially in Shia Beliefs.

Sunnah: In Arabic means "way" or "custom", and therefore, the Sunnah of the prophet means "the way of the prophet", or what is commonly known as the *Prophet's traditions*. Terminologically, the word 'Sunnah' in Sunni Islam means the deeds, sayings and approvals of Muhammad during the 23 years of his ministry, and this means that whatever he did during his ministry as a prophet and messenger of Allah is considered a Sunnah, which Muslims are recommended to follow. In Shi'a Islam, the word 'Sunnah' means the deeds, sayings and approvals of Muhammad and the twelve Imams who Shi'a Muslims believe were chosen by Allah to succeed the prophet and to lead mankind in every aspect of life.

Hakeem: Is a title given to a practitioner of Herbal Medicine which is referred to as *Hikmat*.

Halaal: Is an Islamic Arabic term meaning "permissible". In English it is most frequently used to refer to food that is permissible according to Islamic law. In Arabic it refers to anything that is permissible under Islam.

Sheikh: Is a word in the Arabic language meaning elder of tribe, lord, a revered old man, or Islamic scholar.

The term literally means a man of old age, and is used in that sense in Qur'anic Arabic. Later it came to be a title meaning leader, elder or noble, especially in the Arabian Peninsula, where sheikh became a traditional title of a Bedouin tribal leader in recent centuries.

In Sufi tariqah (orders), it is an honorific for an elder Sufi who has been authorized by the order to teach, initiate dervishes (monks) and otherwise lead a Sufi circle in a Dargah (monastery). In this sense, it is not restricted to Sufi elders, but to any learned men in religion, such as faqihs, muftis, and muhaddiths.

The title is often more informally used to address learned men as a courtesy.

Islamophobia: Is a neologism referring to a fear, and accompanying hostility, towards the religion of Islam and its adherents. Muslims consider these feelings to be the product of ignorance, irrationality, or mere prejudice.

Traditional Islam: refers to a body of Islam which acknowledges that the Quran, Hadith, examples of early companions and scholarly consensus are the corner stones of Islamic thought and practice. Traditional Islam also recognises the importance of classical schools of theology and jurisprudence. Also synonymous with traditional Islam is the centrality of Islamic mysticism (Sufism, Tasawwuf and Ilm Al Nafs). The method of traditional Islam is through a chain of transmission that goes back to the prophet Muhammad so for example Hadith are taught by scholars who have gained authorisation from their teachers so on and so on back to the prophet. This process not only entails learning verbatim the text of the Hadith but also learning implicitly the inner meaning and object of the Hadith which is being lived by a scholar who has been imbued with prophetic utterances. This process brings with it humbleness, dignity and respect before creation because the prophet was sent as a teacher and a mercy to the worlds.

Narrated by Ahmed: See above sections on Sunnah and Hadith. Also Ahmed in this context is a well known narrator of a Hadith.

Mufti Sahib: A mufti is an Arabic term that refers to a learned Muslim scholar who is able due to his or her qualification able to give legal rulings based on Quranic, Hadith and Sunnah and evidence that has been accumulated through precedence of Muslim legal thought resulting from consensus of scholars. There are also principles that a mufti would employ to reaching a verdict these principles are in of themselves contained within the Quran and Sunnah. So if there is no textual proof then a Muslim scholar would by use of principles deduce legal rulings that would expedite social, religious, criminal and economic matters. Sahib is a Hindi word of affection and or respect.

Taweez: Is an amulet (usually silver and or made from cotton) that is worn around the neck and or upper arm. The Amulet contains paper on which Quranic inscriptions and prayers of protection are usually written. These are worn by people from certain Muslim backgrounds as a protection from evil beings such as Jinns, evil magic (this is not to say there is good magic in Muslim tradition but rather to avoid using the word black magic). Taweez can also be used as part of a healing process which supports the body, mind and spirit of a person.

Maulvi: Is an Urdu word that refers to a learned person in the mosque and or person who leads religious ceremonies (marriage) and prayer.

Alim: typically refers to a learned person and or scholar. **Alima** or **Muallim** would refer to a female scholar.

Mehram: Is an Arabic word denoting an escort of a woman who is travelling. The escort is usually male and to whom the lady travelling can not get married to i.e. father, brother, grandfather, uncle

Talawat room: Talawat signifies recitation and usually is referred to when a person is reciting the Quran

Salawat: Salawat is an Arabic word meaning to ask Allah (SWT) to send peace and blessings on his Prophet on behalf of the supplicant.

10. Appendix

10.1 Focus Group Questions

- 1) (a) How would you describe your personal identity?
(b) How important is your faith to you in terms of who you are as a person.
- 2) (a) What are your experiences and what are the issues faced by Muslims living in Britain?
(b) Do you feel broader international situation have implications on your experiences as a British Muslim (i.e.) Iraq, Bosnia, Afghanistan
- 3) (a) What factors/issues are important to you when you consider “mental health” well being?
(b) How do you see the relationship between mental health or well being and the way Muslims are seen in society today?
- 4) (a) What are your experiences direct/indirect of using Mental health services
(b) If you were in a position to plan a service for your Muslim community, what would you do, what is your ideal service?
- 5) (a) What support would you seek in times of crisis?
(b) Would you prefer alternative forms of support?
e.g Pir, Hakeem, Mufti, Alim.....
- 6) (a) Do you feel there is such a thing as Islamaphobia?
(b) Have you had any experience of this?

10.2

Questionnaire for Semi-structured Interview

The guidance points are to assist in the discussion arising from the questions, and not to direct the answer in any way, but rather open the discussion for further points to be raised.

1. What does it mean being a Muslim in Britain today?

- Feel Discriminated against
- Feel as a minority
- United as a community
- Feel scared

2. What does well being mean to you?

- Feeling good
- Meaningful relationships with Family/friends
- Employment
- Confidence
- Financial Security
- Debt Free
- Daily chores
- Socialising having an active life
- Actively practising your faith “deen” and “duniya”

3. What resources/ organisations are you familiar with, or have knowledge of?

- S.V. B
- Naye Subha
- Counseling
- CTRT
- C.A.B
- C.M.H.T
- AOT
- Lynnfield Mount
- Islamic circles

4. What are the appropriate needs of a Muslim mental health service user in Britain?

- Diverse Food (Black/White Muslims)
- Safe Space
- Employment/Education support
- Practical support childcare, benefits etc

5. Are you aware of what Islam says about mental health?

- Have you received or had any information on Islam and mental health.

6. What support would you seek in time of need or when in crises?

- G.P.
- Family
- Friends
- Self healing
- Community groups
- Self help groups
- Crisis Resolution
- Social Services

7. Have you ever had direct contact with mental health services?

8. If so what were the services used?

9. Did you feel your needs were being met?

- Did you feel the services were appropriate?
- What was useful about the services
- What do you feel could be improved or what changes would you like to see?

10. Could you discuss a little about the help offered?

- Tablets
- Talking
- Or other forms of support

11. What did you think about this?

12. How has the distress affected you?

- Feeling sad/angry
- Feeling in despair

13. Were there strange things going on around you?

- Hearing voices
- Seeing shadows
- Hallucinations

14. Was it like a spiritual experience surrounding you?

- Possessed
- Controlled
- Taweez
- Ginns

15. What did you feel you required from these experiences?

- Support
- Understanding
- Guidance

16. Would you like to add any further comments or raise any further questions?

- What has not been asked?
- Was the questionnaire understandable?
- Feedback
- What will happen with the information?

10.3

Core questions

Age:

Gender: Male Female Transgender Transsexual

Ethnicity:

Were you born in the UK? Yes No

If no how long have you lived here?

Citizenship:

British citizen Yes No

refugee Yes No

Asylum seeker Yes No

Other.....

Language(s)

Spoken

Written.....

What is your religion?

Christian Sikh Hindu Muslim Jewish

Buddhist

Other.....

Sexuality:

Lesbian Gay Heterosexual Bi sexual

Do you have a disability?

Yes No

If yes please

advise.....
.....
.....

10.4

Focus group data (core questions)

Focus Group 18-25

No.	Age	Gender	Ethnicity	Born in UK	Citizenship	Languages		Religion	Sexuality	Disability	Lenght of stay	Number of languages	
						Spoken	Written					Spoken	Written
1	19	Male	Indian	Yes	Islam	English,Hindi,Urdu	No	Islam	Hetrosexual	No	Birth	3	1
2	24	Male	Indian	Yes	British	Englis,Urdu,Punjabi	English	Islam	Hetrosexual	No	Birth	3	1
3	23	Male	Bangladeshi	No	British	English,Bangali	English	Islam	Hetrosexual	No	15 years	2	1
4	24	Male	Bangladeshi	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
5	22	Male	Pakistani	Yes	British	English,Urdu	English	Islam	Hetrosexual	No	Birth	2	1
6	25	Male	Pakistani	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
7	23	Male	Pakistani	Yes	British	English,Punjabi	English	Islam	Hetrosexual	No	Birth	2	1
8	22	Male	Pakistani	Yes	British	English,Urdu, Punjabi	English	Islam	Hetrosexual	No	Birth	3	1
9	22	Male	Pakistani	Yes	British	English,Urdu, Punjabi	English	Islam	Hetrosexual	No	Birth	3	1
10	23	Male	Pakistani	Yes	British	English,Urdu, Punjabi	English,Urdu	Islam	Hetrosexual	No	Birth	3	2

Focus group 26-40

No.	Age	Gender	Ethnicity	Born in UK	Citizenship	Language(s)		Religion	Sexuality	Disability	Lenght of stay	Number of languages	
						Spoken	Written					Spoken	Written
1	36	Male	Indian	Yes	British	English,Gujrati	English	Islam	Hetrosexual	No	Birth	2	1
2	28	Male	Indian	No	British	English, Gujrati	English	Islam	Hetrosexual	No	25 years	2	1
3	29	Male	Bangladeshi	Yes	British	English,Bangali	English	Islam	Hetrosexual	No	Birth	2	1
4	28	Male	Indian	Yes	British	English,Urdu	English	Islam	Hetrosexual	No	Birth	2	1
5	27	Male	Pakistani	Yes	British	English,Urdu	English	Islam	Hetrosexual	No	Birth	2	1
6	40	Male	Pakistani	No	British	English,Urdu	English	Islam	Hetrosexual	No	27 years	2	1
7	38	Male	Pakistani	Yes	British	English,Urdu,Punjabi	English	Islam	Hetrosexual	No	Birth	3	1
8	40	Male	Pakistani	Yes	British	English,Urdu	English,Urdu	Islam	Hetrosexual	No	Birth	2	2
9	33	Male	Pakistani	No	British	English,Urdu,Punjabi	English	Islam	Hetrosexual	No	7 years	3	1
10	32	Male	Pakistani	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1

Focus group Convert/Black

No.	Age	Gender	Ethnicity	Born in UK	Citizenship	Language(s)		Religion	Sexuality	Disability	Lenght of stay	Number of languages	
						Spoken	Written					Spoken	Written
1	27	Male	African	No	British	English, Arabic	English,Arabic	Islam	Hetrosexual	No	13 years	2	2
2	26	Male	African	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
3	27	Male	African	No	British	English, Arabic	English,Arabic	Islam	Hetrosexual	No	6 years	2	2
4	30	Male	African	No	British	Arabic	English	Islam	Hetrosexual	No	20 years	2	1
5	30	Male	African	No	British	English	English	Islam	Hetrosexual	No	14 years	1	1
6	33	Male	African	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
7	25	Male	Mixed	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
8	23	Male	British	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
9	26	Male	British	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
10	30	Male	British	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
11	33	Male	British	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
12	25	Male	African	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1

Focus Group 18-
25

No.	Age	Gender	Ethnicity	Born in UK	Citizenship	Languages		Religion	Sexuality	Disability	Lenght of stay	Number of languages	
						Spoken	Written					Spoken	Written
1	19	Male	Indian	Yes	Islam	English,Hindi,Urdu	No	Islam	Hetrosexual	No	Birth	3	1
2	24	Male	Indian	yes	British	Englis,Urdu,Punjabi	English	Islam	Hetrosexual	No	Birth	3	1
3	23	Male	Bangladeshi	No	British	English,Bangali	English	Islam	Hetrosexual	No	15 years	2	1
4	24	Male	Bangladeshi	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
5	22	Male	Pakistani	Yes	British	English,Urdu	English	Islam	Hetrosexual	No	Birth	2	1
6	25	Male	Pakistani	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
7	23	Male	Pakistani	Yes	British	English,Punjabi	English	Islam	Hetrosexual	No	Birth	2	1
8	22	Male	Pakistani	Yes	British	English,Urdu, Punjabi	English	Islam	Hetrosexual	No	Birth	3	1
9	22	Male	Pakistani	Yes	British	Punjabi	English	Islam	Hetrosexual	No	Birth	3	1
10	23	Male	Pakistani	Yes	British	English,Urdu, Punjabi	English,Urdu	Islam	Hetrosexual	No	Birth	3	2

Focus group 18-25													Number of languages	
No.	Age	Gender	Ethnicity	Born in		Language(s)		Religion	Sexuality	Disability	Lenght of stay	Number of languages		
				UK	Citizenship	Spoken	Written					Spoken	Written	
1	21	Female	Indian	Yes	British	Punjabi	DNA	Islam	Hetrosexual	No	Birth	1	0	
2	21	Female	Indian	Yes	British	English,Punjabi	DNA	Islam	Hetrosexual	No	Birth	2	0	
3	21	Female	Indian	Yes	British	English,Punjabi	English	Islam	Hetrosexual	No	Birth	2	1	
4	19	Female	Bangladeshi	Yes	British	English,Urdu	DNA	Islam	Hetrosexual	No	Birth	2	0	
5	24	Female	Pakistani	Yes	British	Punjabi	DNA	Islam	Hetrosexual	No	Birth	1	0	
6	24	Female	Pakistani	Yes	British	English,Punjabi	English	Islam	Hetrosexual	No	Birth	2	1	
7	22	Female	Pakistani	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1	
8	23	Female	Pakistani	Yes	British	English,Punjabi	English	Islam	Hetrosexual	No	Birth	2	1	
9	22	Female	Pakistani	Yes	British	English,Patwari	English	Islam	Hetrosexual	No	Birth	2	1	
10	23	Female	Pakistani	Yes	British	English,Punjabi,Urdu	English	Islam	Hetrosexual	No	Birth	3	1	
11	23	Female	Pakistani	Yes	British	English,Punjabi	English	Islam	Hetrosexual	No	Birth	2	1	
12	24	Female	Pakistani	Yes	British	English,Urdu	English	Islam	Hetrosexual	No	Birth	2	1	
13	23	Female	Pakistani	Yes	British	English,Punjabi	English	Islam	Hetrosexual	No	Birth	2	1	
14	18	Female	Pakistani	Yes	British	English,Urdu	English	Islam	Hetrosexual	No	Birth	2	1	
15	20	Female	Pakistani	Yes	British	English,Urdu	English	Islam	Hetrosexual	No	Birth	2	1	

Focus group 26-40

No.	Age	Gender	Ethnicity	Born in UK	Citizenship	Language(s)		Religion	Sexuality	Disability	Lenght of stay	Number of languages	
						Spoken	Written					Spoken	Written
1	39	Female	Bangladeshi	Yes	British	English,Bangali	English	Islam	Hetrosexual	No	Birth	2	1
2	40	Female	Pakistani	Yes	British	English,Urdu	DNA	Islam	Hetrosexual	No	Birth	2	0
3	28	Female	Pakistani	Yes	British	English,Pushto	English	Islam	Hetrosexual	No	Birth	2	1
4	28	Female	british	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
5	26	Female	Indian	Yes	British	English,Urdu	English	Islam	Hetrosexual	No	Birth	2	1
6	27	Female	Indian	Yes	British	English,Punjabi	DNA	Islam	Hetrosexual	No	Birth	2	0
7	38	Female	Pakistani	Yes	British	english,urdu	english,urdu	Islam	Hetrosexual	No	Birth	2	2
8	26	Female	Pakistani	No	British	urdu,punjabi,english	English	Islam	Hetrosexual	No	24 years	2	1
9	27	Female	Pakistani	No	British	english	English	Islam	Hetrosexual	No	16 years	1	1
10	29	Female	Pakistani	No	British	english,urdu	english,urdu	Islam	Hetrosexual	No	28 years	2	2
11	40	Female	Pakistani	Yes	British	english,urdu,punjabi	English	Islam	Hetrosexual	No	Birth	3	1
12	27	Female	Pakistani	Yes	British	english,patwari	English	Islam	Hetrosexual	No	Birth	2	1
13	36	Female	Pakistani	Yes	British	english,punjabi	English	Islam	Hetrosexual	No	Birth	2	1
14	29	Female	Pakistani	Yes	British	english,punjabi	DNA	Islam	Hetrosexual	No	Birth	2	0

Focus group Revert/Black

No.	Age	Gender	Ethnicity	Born in		Language(s)		Religion	Sexuality	Disability	Lenght of stay	Number of languages	
				UK	Citizenship	Spoken	Written					Spoken	Written
1	22	Female	African	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
2	30	Female	African	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
3	32	Female	African	No	British	english,arabic	English	Islam	Hetrosexual	No	15 years	2	1
4	29	Female	British	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
5	28	Female	British	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
6	26	Female	British	Yes	British	English	English	Islam	Hetrosexual	No	Birth	1	1
7	24	Female	Indian	Yes	British	Hindi,english	English	Islam	Hetrosexual	No	Birth	2	1
8	23	Female	Indian	Yes	British	french,urdu,english	English	Islam	Hetrosexual	No	Birth	3	1

Mixed Focus Group

NO	AGE	Gender	Ethnicity	Born in		Languages		Religion	Sexuality	Disability	Lenghts of stay	
				UK	Citizenship	Spoken	Written					
1	24	Female	Indian	Yes	British	English,Urdu	English	Islam	Hetrosexual	No	Birth	
2	26	Female	Pakistani	Yes	British	English,Punjabi	English	Islam	Hetrosexual	No	Birth	
3	23	Male	Pakistani	Yes	British	English,Punjabi	English	Islam	Hetrosexual	No	Birth	
4	21	Male	Pakistani	Yes	British	English,Punjabi	English	Islam	Hetrosexual	No	Birth	
5	21	Male	Pakistani	Yes	British	English,Punjabi	English	Islam	Hetrosexual	No	Birth	
6	22	Male	Pakistani	Yes	British	English,Punjabi	English	Islam	Hetrosexual	No	Birth	
7	33	Male	African	No	British	English,Arabic	English	Islam	Hetrosexual	No	20	
8	26	Male	Mixed	Yes	British	English	English	Islam	Hetrosexual	No	Birth	

10.5

Semi-structured interview data (core questions)

Semi-Structured interviews

NO	AGE	Gender	Ethnicity	Born in		Languages		Religion	Sexuality	Disability	Lenghts of stay
				UK	Citizenship	Spoken	Written				
1	34	Male	pakistani	Yes	British	english,patwari	english	Islam	Hetrosexual	No	Birth
2	22	Male	pakistani	Yes	British	english,patwari	english	Islam	Hetrosexual	No	Birth
3	22	Male	pakistani	Yes	British	english,punjabi	english	Islam	Hetrosexual	No	Birth
4	33	Male	African	Yes	British	arabic,english	english	Islam	Hetrosexual	No	Birth
5	34	Male	British	Yes	British	english	english	Islam	Hetrosexual	No	Birth
6	36	Male	African	Yes	British	English	english	Islam	Hetrosexual	No	Birth
7	20	Female	Pakistani	Yes	British	Pushto	Urdu	Islam	Hetrosexual	No	Birth
8	22	Female	pakistani	Yes	British	urdu,english	English	Islam	Hetrosexual	No	Birth
9	26	Female	Indian	Yes	British	english	english	Islam	Hetrosexual	No	Birth
10	30	Female	Indian	Yes	British	english,urdu	english	Islam	Hetrosexual	No	Birth
11	24	Female	British	Yes	British	english	english	Islam	Hetrosexual	No	Birth
12	28	Female	British	Yes	British	english	english	Islam	Hetrosexual	No	Birth

10.6 Project Plan

Below is a brief overview of the project plan, but may or may not change subject to the outcomes of each stage.

The age range we will be focusing upon is 18-40 year olds.

Methodology will be focus groups and interviews.

July

- Reviewing proposal plan
- Identified steering group members
- Letter with terms preference
- Meeting/dates
- Report writing
 - Background on community researchers
 - Why you have participated
 - History / Background on Bradford – SV(B)
- To start questionnaire and complete first draft

August

- Finalise questionnaire(s)
- Pilot questionnaires
- Structure focus groups

September

- To arrange a meeting within first week with steering group
- Field work - interviews and focused groups (up to eight)

October

- Field work continued
- Report writing

November

- 8th,9th,10th Workshops
- Second steering group meeting (towards end of November)
- Analyzing data and information

December

- Continue analysing data

January/February/March

- Write up summary for steering group
- To have third steering group meeting in mid February
- Complete report

10.7

Confidentiality statement

Aim

The purpose of this questionnaire is to gather the views and opinions of Muslim individuals and communities in Bradford between the ages of 18-40, in relation to their understandings of mental health and well being. Furthermore, to explore to what degree their needs have been met by services in times of crisis and how to improve access and services received.

Individuals participating in this questionnaire should be aware of the following points;

- Sharing Voices Bradford (SVB) would like to help improve mental health services by listening to what the Muslim community has to say about the current services that are being offered.
- Your feedback will be considered highly confidential and will only be used for research purpose in order to improve existing services.
- Your personal details will not be passed on to anyone else.
- The information taken from the questionnaires and research findings maybe published whilst protecting your identity
- Answer as many of the questions as possible
- Please feel free to make any further comments, at either the end, or during the interview or focus group.

Methodology

The community researchers will facilitate 8-10 focus groups that will be organized in the following categories.

1. 18-25 year old
2. 25-40 year old
3. Reverts and Black Muslims
4. Those visited GP only
5. Those ended up in hospital

All groups will be gender specific.

All groups will incorporate Disable people

The community researchers will also conduct 10-20 semi-structured interviews.
(Participants to be agreed)

Risk of participation

Sharing Voices will provide a safe space for participants to have a debriefing session after each focus group and will provide one to one support in order to prevent the

participant from becoming distressed. SVB will also signpost participants where necessary to relevant agencies.

Benefits:

- Express themselves
- Be part of research, possibly influencing policy and practice change and development
- Building of self- confidence
- Gain wider knowledge of services available
- Networking
- Greater understanding
- Creates a safe-space
- Reducing isolation by inviting them to participate in research to meet like minded people.

How the information will be used?

The information will be presented to individuals who participated in the research who will have the opportunity to make amendments and provide feedback. The information will be used to compile a report, illustrating findings and strong recommendations to be disseminated locally and nationally. All information given by participants will remain anonymous.

Confidentiality

- No names
- Anonymity
- Destroying of evidence that will be obtained, such as recordings and writings.

Entirely voluntary

Participation and time will be appreciated and highly valued. This will be entirely voluntary and if at any time you wish to withdraw, please advise.

10.8 Statement of Informed Consent

This consent form is to make sure that you understand what is involved in this research project, and how we intend to use the information you are giving us.

We will not use any names or other identifying features when we write about what we have found out. All identities will be kept confidential, unless you specifically give us permission to acknowledge you. We will not do anything with this information that you do not give us permission to do.

I understand that my participation in this research project is voluntary and I understand that I can withdraw at any point without giving a reason. I have had the opportunity to ask questions about my involvement in this research project.

I agree to the research team transcribing the interview, keeping it safely on computer, and using it for the purposes of this study. I understand that only members of the project research team will be allowed access to the interview transcript.

Providing my identity is kept confidential, I give permission for Sharing Voices (Bradford) researchers to use the information which I am about to give in the following ways:

- In preparation of a research report for the National Institution of Mental Health in England and University of Central Lancashire.
- In any events or written reports which tell the communities who have contributed to the research about the research findings.
- For academic or policy related purposes, which help to make the findings of the research known.

I understand that I will be sent a copy of the transcript of the interview when this is available, and a short summary of the final report.

I hereby assign the copyright in my contribution to Sharing Voices (Bradford).

Signed: _____

Name: _____ Date: _____

I would like my copy of the interview and report sent by: Post Email

Address: _____

Email: _____

I have explained the purposes of this research.

I agree to keep all interview details confidential.

Name: _____ Signature: _____

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