WRITTEN EVIDENCE TO THE DEPARTMENT OF HEALTH & SOCIAL CARE OPEN CONSULTATION ON MENTAL HEALTH AND WELL BEING PLAN: DISCUSSION PAPER

July 2022

Introduction

1. Muslim Women's Network UK (MWNUK) is a national Muslim women's organisation in Britain (www.mwnuk.co.uk) that has been advancing equality, promoting women's empowerment, and connecting voices since 2003. We are a small national charity (reg. no. 1155092) that works to improve social justice and equality for Muslim women and girls. Our membership also includes women of other faiths or of no faith and men who support our work. We find out about the experiences of Muslim women and girls through research and our helpline enquiries. We identify policy and practice gaps and use this information to inform decision makers in government as well as informing our community campaigns at a grassroots level.

2. We also develop resources and train women, so they are better aware of their rights. We have a separate website for our national helpline (www.mwnhelpline.co.uk) that provides advice and support on a range of issues including domestic abuse, forced marriage, honour-based violence, sexual exploitation and abuse, female genital mutilation, hate crimes, discrimination, mental health etc.

3. The impact of our work is particularly felt in reducing the vulnerability of Muslim women and girls, reducing the prejudice they face, and giving them greater access to rights and services – all of which allow them to contribute to society like any other citizen. We are also creating a critical mass of voices to influence change with more women being confident to challenge discriminatory practices within their communities and in society and to influence policy makers.

4. The term 'racialised minority (communities)' has been used because unlike 'BAME,' it does not privilege or erase any particular social group according to real or imagined physical characteristics such as skin colour, within a system where 'whiteness' is considered the norm. Conversely, it does acknowledge that all groups are subjected to processes of racialisation, that they are not part of a single minority but may be located at the intersection of several different minoritised groups. However, the term 'BAME' (Black, Asian, and Minority Ethnic) or 'minority ethnic groups' has also been used because its use is more widespread in the UK.

Evidence

5. Mental health is an area that disproportionately impacts the racialised minority populations in the UK. Whilst religion is often not recorded current research shows that South Asian women, Pakistani women (many of whom are Muslim), show higher rates of Anxiety and Depressive disorders. This is not surprising considering that people who are unpaid carers or have experienced (or are currently experiencing) violence or abuse, displacement, unemployment, and housing instability are at a greater risk of developing a mental health condition. Many Muslim women experience several of these risk factors, whilst simultaneously having pressure to put their family's honour and need above their own wellbeing.

6. Therefore, as the only national charity providing a frontline service to Muslim women and girls in the UK it is unsurprising that we deal with many women experiencing mental health struggles. Our helpline evaluations (https://www.mwnuk.co.uk/muslim-women-helpline-dashboard.php) show that mental health has been in the top three issues for callers to the Muslim Women's Network Helpline and in 2020 & 2021 it overtook domestic abuse at the most common issue.

7. From 2016, MWN have provided a specialist culturally sensitive counselling service for Muslim women. The number of referrals and clients served have increased each year. We provide a free short-term talk therapy intervention that aims to help the client to explore feelings and emotions in an empathetic, open, and non-judgemental environment. This quickly established a good reputation amongst clients and referring organisations such as Birmingham Women's Aid. The service has gone from strength to strength, despite a backdrop of the COVID-19 pandemic and soaring mental health referral rates.

8. MWN also deliver mental health workshops tailored for the Muslim community. These aim to increase awareness of mental health, increase confidence in speaking about mental health with other, decrease stigma regarding mental health problem and to increase willingness to seek help and advise others to seek help for mental health problems.

9. We will be drawing on our internal Counselling evaluation service report (2019 - 2021) and our mental health awareness workshops delivered to the Muslim communities in Wandsworth report, to respond to this consultation.

10. We now respond to the questions of the Consultation as follows:

How can we help people to improve their own wellbeing?

11. Stigma towards mental health problems is a well-known fact that cuts across all of society regardless of social class, gender or ethnicity which can prevent people from accessing support or talking about mental health struggles. Mental health awareness workshops and education have worked to challenge this stigma. However, the 'one size fits all' approach to mental health awareness and education can be insufficient to address misconceptions and stigmas about about mental illness and mental wellbeing

that may be particular to, or more prevalent, in communities of faith and for those from racialised minority backgrounds. For example, Muslim communities can perceive mental illness as a test or punishment from God, a weakness of faith, God's will which must be accepted or because of Black Magic, Evil Eye or spirit (jinn) possession. Muslim women may internalise mental health struggles as they put the needs of the family before their own needs. Therefore, a 'one size fits all' approach to mental health education can fail to address stigma and beliefs within these communities. A more effective approach is to develop workshops tailored for racialised minority groups and communities of faith that approaches mental health education in nuanced ways.

12. To combat this MWN have developed educational mental health awareness workshops created by and for Muslim communities, particularly women within these communities. It was important that these workshops were tailored to, created by and led by people from these communities to provide a safe non-judgemental space to air for participants to air beliefs about mental health. This then allows us to challenge them. Through our workshops, such as those carried out in Wandsworth, we highlight what Islam says about mental health and the contributions of Islamic scholars to the fields of psychology and mental health centuries ago. We presented differing religious views to challenge beliefs such as suicide being a sin. We also provide information on how to be safe when using faith healers. Importantly we also have found that fostering empathy for those experiencing mental illness was effective at tackling stigma and equipped participants to better understand mental illness. Opportunities for conversations like this are absent from generalised mental health education workshops and highlight the importance of nuanced and culturally specific approaches to mental health wellbeing and education and enables participants to view their mental wellbeing and the wellbeing of those around them, in a different light.

Do you have any suggestions for how we can improve the population's wellbeing?

13. Community plays an important role in improving mental wellbeing. For those from racialised minority groups and communities of faith, community can make a fundamental difference to mental wellbeing, including negatively. Therefore, it is important to provide opportunities for individuals (particularly those most marginalised) to build and foster positive community relations. At MWN we are currently setting up walking groups across England and training women in becoming walk leaders to then encourage other Muslim women to access outdoor spaces and use the walking group as an opportunity to improve their physical and mental wellbeing. This provides Muslim women opportunities to connect with each other and to widen their community through positive interactions. For women who are not in employment and who carers and/or housewives (which is more common for Muslim racialised minority women compared to White women), this is essential as opportunities to build relationships and expand their community can be limited.

14. Individuals need to be empowered to have conversations about mental health within their families and communities. Over half of the participants in the workshops in Wandsworth stated that they would help and support those with mental health

problems and 40% said they would share the information from the workshop with others. In a follow-up questionnaire a year later 83% reported that they had shared what they learnt, mainly with family and friends. One participant reported delivering two presentations on mental health, stigma and available resources at a mosque. This outcome highlights the far-reaching impact of tailored and nuanced mental health education. These individuals were better equipped with the ability to challenge misconceptions held within their communities about mental health.

15. However, education can only go so far. COVID-19, and the mismanagement of the crisis, exposed and widened health inequalities for racialised minority communities. Infection and death rates were higher for Black Africans, Black Caribbeans, Bangladeshis and Pakistanis than the White population. This is illustrative of socioeconomic, but also raises issues of community trauma lowering the mental wellbeing of members of these communities. There needs to be targeted action to address this and specialist support services and those providing counselling for these communities need to receive the funding to meet increased demand for these services.

16. Factors such as socio-economic disadvantage, employment status, ethnicity (correlated with socio-economic disadvantage and insecure/inadequate housing) and being a victim of violence (including domestic and sexual violence) have all been shown to make individuals vulnerable to mental illness. The impact of COVID-19 (economically and COVID-related trauma), inflation, the current cost of living crisis and lack of funding to specialist domestic violence services means those that are most vulnerable are less able to access support and there are more people vulnerable to lower mental wellbeing. Without this being addressed the wellbeing of these communities will likely decline.

What is the most important thing we need to address in order to reduce the numbers of people who experience mental ill-health?

17. COVID-19 exposed and worsened health inequalities within this country, particularly between racialised minority groups and White populations. Development and funding of services built to address the needs of racialised minority groups and communities of faith is essential to working towards closing the health gap across the country. This includes tailored workshops as already mentioned, but also interventions that are faith and culturally sensitive. Interventions need to be adapted to better serve the client, otherwise they will be less effective, particularly for marginalised individuals. For racialised minority groups and communities of faith generalised interventions may be ineffective as individuals feel that they cannot consolidate therapeutic advice with cultural pressures and religious beliefs.

18. MWN have provided a faith and culturally sensitive counselling service since 2016 and demand has increased every year. Our clients report negative experiences with mainstream mental health services and cite a lack of understanding of cultural and religious factors as one of the most significant reasons. Those who have accessed our counselling service have contrasted their experiences with our service with mainstream services. These quotes from clients highlight how important

understanding and considering cultural factors and faith is to recovery and equipping them with the skills needed to aid recovery.

- "*I have had counselling previously with a non-Muslim counsellor and I did not feel seen or heard. I felt they did not understand how things affected me, given my life circumstances. I did call a non-Muslim helpline and it was a waste of time. Their view of stuff is completely different, it seemed like they were reading off a prepared script. The way their viewed things was very individualistic, telling me to only take care of myself."* (T, MWN client)

- "*And the counsellor ever that I was speaking to through Mind, didn't get the issues that I was talking about. Religious, spiritual things, even just general cultural aspects that I didn't feel comfortable discussing. Whereas the counsellor with your service was absolutely in tune with all aspects from the Western concepts to the Eastern concepts. Also, religious concepts, so I thought it was really beneficial*." (H, MWN client)

- "*I would be worried I wouldn't get the right advice, if that makes sense. Would I get the cultural understanding? It would be almost as though they think that you're being weird. They don't understand our cultural norms. Yeah, I think I would be so worried all the* time." (K, MWN client)

19. Long waitlist times are severely impacting those who are experiencing mental ill-health. Although we currently can only provide short-term counselling, counsellors can request further sessions for more complex cases. However, often even clients with seemingly simple presenting issues will have layered and complex factors impacting their mental health. For example, if a woman calls the Helpline for help regarding getting a divorce there are many questions we need to answer including:

- Has this person been forced into that marriage?
- Are they at risk of honour-based violence?
- Have they faced abuse or rape within the marriage?
- Was the marriage legally registered?

This then all informs the counselling they require and receive. This has led to more clients having additional sessions which has increased waitlist times. This in addition to a rise in referrals in 2020-21 placed intense pressure on the service and the waitlist had to be temporarily closed at the end of 2021. We need to scale up our counselling service to meet the increasing demand and to provide longer interventions. However, this can only be done with sufficient funding to allow us to hire additional counsellors.

What is the most important thing we need to address to prevent suicide?

20. For those from racialised minority groups and communities of faith there can be additional barriers to accessing help for mental health problems such as stigma, language barriers, socio-economic status, institutional racism and discrimination[1,2].

21. Studies have confirmed that the rates of suicide and suicidal attempts are higher in young South Asian women.[3] This may be due to:

- Pressure to preserve family honour and maintain tradition and culture
- Being expected to suffer in silence due to shame and honour
- Restrictions on their freedoms leading to social isolation
- Being blamed for familial problems e.g., domestic violence, divorce, marital affairs
- Language barriers to accessing support
- Polygamy
- Religious pressure
- Abuse from partners, extended family, and in-laws

22. To address these factors, these communities need to have access to support that is reflective of their needs. MWN's counselling service provides free access to faith and culturally sensitive therapeutic interventions in which counsellors combine Western psychological theory and practice with their knowledge of both cultural and Islamic precepts and norms. Religion plays a large role in the world view and lives of many Muslim women, their relationship with God and spirituality can be a key component of both mental health troubles and healing.[4] MWN choose the perspectives and modalities best suited for their client's needs, including Islamic precepts and rubrics that are not usually part of a non-Muslim counsellor's tool box.

23. MWN's counselling service is effective in enabling the client to be seen, heard and understood without them having to explain and justify or minimise their culture and beliefs. Clients have reiterated that counsellors' knowledge of their cultural-religious context facilitated a deeper therapeutic relationship and faster focus on issues. One counsellor stated that "people want us to help with disentangle what is Islamic edict and what are cultural norms." This can only be done with a counsellor with a knowledge of both Islam and cultural norms.

24. There continues to be a great demand for a faith and culturally sensitive service. Muslim women feel overlooked by mainstream mental health services and report high barriers to access. When they do avail of them, many experience racism, a lack of cultural context on the part of mental health professionals and an inability to build

[1] The Synergi Collaborative Centre. (2018) The impact of racism on mental health, briefing paper.
[2] Bignall T, Jeraj S, Helsby E, Butt J. (2019) Racial disparities in mental health: Literature and evidence review. Race Equality Foundation.
[3] Ineichen B. (2008) 'Suicide and attempted suicide among South Asians in England: who is at risk?', Mental Health in Family Medicine, 5(3), pp.135-138.
[4] Sadiq, R. (2019). *Understanding Muslim women clients of counselling: An interpretive phenomenological analysis* (Doctoral dissertation, University of the West of England).

authentic therapeutic relationships. This can be an incredibly isolating experience that can make women feel trapped in their circumstances. MWN clients have reported that counselling through our service helped them unlearn negative stereotypes around mental health and embrace help seeking. They described how sessions empowered them with frameworks, perspectives, tools and scripts to tackle difficult situations. Clients told us that their sessions helped them learn how to set boundaries, model positive self-care and recalibrate family relationships. This is all evidence of actionable tools and coping skills that gives agency back to women, but this can only be achieved when clients feel understood first.

What more can the NHS do to help people struggling with their mental health to access support early?

25. The role of the GP in mental health care is crucial to helping people struggling with their mental health and early intervention. This is particularly true for women from racialised communities. 79% of participants in our mental health awareness workshops in Wandsworth, prior to the workshop, identified the GP as a place to get help for a mental health problem. This shows the importance and responsibility of the role of the GP as people expect the GP to be able to help and if they do not receive the help, they need some patients can be deterred from seeking further help. This is reflected in research that has shown that Pakistani women have been found to be less likely to access specialist mental health services than White women, yet no less likely to see a GP for their mental health problems.[5],[6] Also, those from racialised minority groups are less likely to be referred to talking therapies and more likely to be prescribed medication for mental health struggles. First care practitioners need to be able to identify the signs of mental struggle early in individuals from racialised minority backgrounds. We have had individuals contact us through the helpline showing signs of anxiety and depression, which have been overlooked by first practitioners. Stereotypes about racialised minority women can mean that behaviours exhibited indicating anxiety or depression are not attributed to mental health struggles, particularly in the early stages of mental ill health.

26. Furthermore, when they have been referred, Muslim patients have amongst the lowest recovery rates compared to other faiths.[7] Our faith and culturally sensitive counselling service has shown to be incredibly successful with high levels of client satisfaction and recovery results consistent with, or just below, NHS-IAPT recovery rates.[8] These are significant results for Muslim women accessing mental health services and show that to provide the same level of care for racialised minority groups and communities

[5] Kapadia D, Brooks H, Nazroo J, and Tranmer M. (2017) 'Pakistani women's use of mental health services and the role of social networks: a systematic review of quantitative and qualitative research', Health and Social Care in the Community, 25(4), pp. 12041317.
[6] Rees R, Stokes G, Stansfield C, Oliver E, Kneale D, Thomas J. (2016) Prevalence of mental health disorders in adult minority ethnic populations in England: A systematic review. UCL Institute of Education.
[7] NHS Digital. (2016) Psychological Therapies: Annual report on the use of IAPT services - England, 201516.
[8] NHS Digital. (2020) Psychological Therapies, Annual report on the use of IAPT services 2019-20 - England

of faith, services need to meet clients where they are and have their treatment reflect their culture and faith. Funding for specialist services that provide this is essential to expand and meet increasing demand of these communities. GPs need to be better informed of local community services for individuals from these communities, like MWN's counselling service, to refer those who require it.

27. Racialised minority women may be approaching healthcare services with a level of distrust, due to adverse experiences. These women are being referred to specialist mental health services at lower levels than that of White women. This is concerning and can contribute to distrust of healthcare and discourage further help seeking. We need to empower women from racialised minority groups to advocate for their healthcare needs by educating them on how to seek help, what to expect when seeking help, what to do when they feel help is insufficient and different avenues of support.

Do you have any suggestions for how the rest of society can better identify and respond to signs of mental ill-health?

28. MWN's mental health educational workshops tailored to Muslim women in Wandsworth resulted in participants reporting higher levels of empathy with individuals experiencing mental ill-health. Tailored workshops provide a safe space for individuals to communicate their beliefs about mental health, including negative views, so that they can be challenged and to have meaningful discussions around these topics. Generalised workshops may not provide spaces like this for individuals from racialised minority groups or communities of faith for participants being concerned of judgement. Higher levels of empathy resulting from our workshops were most successful in challenging stigma associated with mental illness. Tailored and nuanced education of what it is like to experience mental health that addresses misconceptions and stigma through enabling them to empathise with those who are struggling with their mental health. It also informs participants on how to safely help and where to access treatment. Many participants reported that they felt better equipped to identify and support someone experiencing mental health struggles. A year after the workshop 89% of participants reported sharing what they learnt at the workshops with others. The wider impact of tailored mental health education for racialised minority groups and communities of faith in enabling these communities to identify and respond to those showing signs of mental ill-health is evident.

What should be our priorities for future research, innovation and data improvements over the coming decade to drive better treatment outcomes?

29. For communities of faith and racialised minority groups there can be additional barriers to seeking help for mental health struggles, including (but not exclusive to) religious and cultural stigma, discrimination, racism and distrust of healthcare services. Recovery rates for Muslims who do access mental health services are lower than for those from other faiths, perhaps due to many within this group also belonging to racialised minority groups and facing additional Islamophobic discrimination.[9]

[9] [9] NHS Digital. (2016) Psychological Therapies: Annual report on the use of IAPT services - England, 201516.

Research into this often relies on qualitative data. Therefore, to better understand this, data needs to reflect and chart the experiences of Muslims and racialised minority communities of faith when accessing mental health support services. Valuable information about the barriers those from these backgrounds face, particularly those further marginalised within these communities, is being overlooked.

How can we support sectors to work together to improve the quality of life of people living with mental health conditions?

30. As mentioned throughout this evidence, the effectiveness of tailored mental health services is not disputed. However, our capability to deliver a service that adequately addresses the scale of the mental health crisis within the communities we serve is impeded by insufficient funding. We are only able to provide a short-term counselling service of six sessions. Counsellors report that this is often not enough or limits what they are able to address as the cases they handle working for MWN are often more complicated than those they handle in their day jobs. Charities and organisations providing specialist support such as this need to be funded to meet demand.
31. We would like to expand therapeutic services to include different kinds of therapies such as art therapy to better suit the varying needs of our clients. The full capability of our services cannot be achieved with the limited funding we receive to invest in therapeutic services that are tailored to those from communities of faith and racialised minority groups and developed by people and organisations that are reflective of these faith and cultural backgrounds.

What can we do to improve the immediate help available to people in crisis?

32. To improve the immediate help available to people in crisis existing services that have proven to be successful need to receive the funding necessary to not only maintain their services but to expand to meet increasing need. The waitlists for mainstream generalised mental health services are extensive and the waitlist for specialist services even longer. These specialist services are incredibly successful for individuals whose needs are not being adequately met by generalised mainstream interventions. Specialist services need to be invested in so that people from marginalised groups, particularly racialised minority faith communities, can have access to mental healthcare that is effective for their needs. This is the only way to combat the ever-widening mental health inequalities nationally. This will benefit those in crisis from these communities and reduce the strain on mainstream mental health services.

What would enable local services to work together better to improve support for people during and after an experience of mental health crisis?

33. The reliance on prescription medication over specialist mental health services for racialised minority groups is concerning as it is not addressing mental crises and can result in a deterioration of mental health and a resistance to seek further help. First line practitioners need to be more aware of specialist and community-based services that may be better suited to meet the needs of people from marginalised communities

experiencing mental health crises. Racialised minority women of faith have reported that at times their interactions with mainstream generalised mental health services have not been helpful as the care received has not taken into consideration the relevance of cultural factors and faith on their mental wellbeing and recovery process. Faith can be an important part of the recovery process for people of faith, but cultural factors and narrow religious interpretations can contribute mental health crises. If practitioners do not have an understanding of the culture and faith of their client then it is extremely difficult to support their client to work through this and develop actionable advice to improve mental wellbeing. Skills developed through therapeutic interventions must be relevant and actionable to a client's needs. If not recovery rates for racialised minority women of faith will remain lower and the risk of relapse will be increased. We reiterate again the importance of funding already existing services that are free to access but can only be provided free at the point of access if adequately funded. Services like MWN's counselling service that are faith and culturally sensitive must be expanded to ensure that racialised minority women of faith and other marginalised groups can access mental healthcare that addresses their needs to even begin to close the health inequality gap. Additionally, services like ours should be able to receive support from local NHS service providers to provide more diverse options of therapeutic care, including more informal activity-based group therapies (e.g., walking groups, cooking groups) and art therapies, to meet the diverse needs of those we support. Informal therapeutic interventions, such as cooking interventions, can support communities that may have stigma towards accessing formal therapy or counselling but has been shown to be effective in engaging and retaining people from Muslim and racialised minority communities in therapy. [10]

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[10] Hammad, J., El-Guenuni, A., Bouzir, I., & El-Guenuni, F. (2020). The Hand of Hope: A Coproduced Culturally Appropriate Therapeutic Intervention for Muslim Communities Affected by the Grenfell Tower Fire. *Journal of Muslim Mental Health*, *14*(2).