

Muslim Mental Health

A scoping paper on theoretical models, practice and related mental health concerns in Muslim Communities

The final report

Synopsis

The aim of this scoping paper is to present the current range of service models that specifically address the mental health needs of the Muslim Community in the context of its experience of mental distress or ill health. In doing so the paper presents a combination of demographic information regarding Muslim communities in the UK and experience of mental health needs as recognised by specialist service providers. This is presented in the context of the existing policy drivers regarding mental health. In addition the paper reviews the existing literature regarding theoretical models of working and presents the findings of a series of interviews with specialist providers in the field in relation to their theoretical models of practice. The report presents conclusions and finally a set of recommendations.

Content

Page	Section
3	Executive Summary
5	Policy Drivers
7	The Social Context of the Muslim Community
7	Identity
8	Education and Employment
9	Defining or identifying need
9	Quantitative indicators of need
11	Qualitative indicators of need
17	Literature review
21	Theoretical models of working with Muslims communities
22	Faith based mental health promotion
23	Participant led services
24	Faith based culturally sensitive support and advocacy
27	Culturally sensitive mainstream counselling and faith based counselling or Muslim counselling
29	Islamic counselling
36	Islamic therapy
40	Analysis and Conclusions
43	Recommendations
46	Appendix 1
	A proposed fast track route for the development of Islamic counselling
53	Participants in the scoping process
54	References

Executive Summary

The Muslim community is a significant community experiencing severe social exclusion for a variety of reasons. Though some are related to their cultural identity many are not – social exclusion correlates with mental illness. There are indicators that Muslims experience mental ill health but that they either are unidentified by mainstream mental health services or present late.

Significant sections of the Muslim community identifies predominantly in relation to its faith and through its faith constructs cognitive schemata that enable its members to cope with difficult life events. The active practice of Islamic belief can reframe mental distress and may reduce the incidence of mental illness. This is further reflected through the selection of Islamic models for working with mental ill health.

Many Muslim communities and individuals in the UK are grappling with the transition from a developing or rural conservative communities to liberal urbanised modernity. This has resulted in the renegotiation of or the loss of social norms. The recent events internationally and locally relating to the war on terror and the rise of Islamophobia have increased pressure on Muslims to find ways of rationalising their experience and giving it meaning. This process has increased for some a sense of alienation within UK mainstream society. Since 9/11 more Muslims are identifying themselves by faith and or are looking for support regarding psychological and emotional distress in a context that makes sense within their faith.

Muslims historically have not engaged with mental health services in part due to their experience of services, which do not relate to their cognitive schema, (their psychological framing of self or their understanding of the social world) and in part due to the lack of a language for mental distress in their communities.

Muslim mental health relates to the wider issues of social exclusion experienced within these communities taking into consideration education, crime and youth offending, social care and housing amongst other factors. In this the significance of faith as a means of enabling well-being has importance. There is a need to develop appropriate partnerships with Muslims communities, recognising of their strengths and negotiating shared a shared language for understanding mental health, and objectives between service providers (across the sectors) and community members regarding an agenda for improved mental health within the community.

Existing theoretical models of practice within the Muslim community vary in the ways that they work with layers of understanding and key themes within Islamic cognitive schemata. The variety encompasses models of working based on cultural or religious similarity and shared understanding, detailed Islamic models of the self, well being and related interventions and integrated Islamic models

incorporating Jungian, systemic or other contemporary theoretical models. In the context of understanding mental health in contemporary Muslim communities there is a need for the experience and identities of Muslims to be documented in a way that enables a clear understanding of modern Muslim mental health and the meanings of mental distress or ill health to Muslims. In addition there is a need to develop the evidence base in relation to the existing alternative theoretical models. This should also explore ways in which effective work can be supported or proliferated.

There is a need for the development of a skilled workforce within both the statutory and voluntary sectors that is able to work therapeutically with Muslims in the context of their faith through such processes as Islamic counselling.

There is further a need to develop clear strategies for working with Muslim communities or sections of the communities be that in terms of age gender ethnicity or sect at local levels in relation to the specific presentations of mental ill health and in partnership with other agencies the causal or social factors relating to mental illness or distress

Policy Drivers

This document is prepared in the context of a range of social policy relating to mental health with specific reference to health inequalities. These policy drivers include:

The National Service Framework for Mental Health 2004

Standard One. Health and Social Services should promote mental health for all working with individuals and communities combating discrimination against individuals and groups with mental health problems.

Standard Two. Any service user who contacts their primary health care team with a common mental health problem should be offered effective treatments including referral to specialist services for further assessment, treatment or care if required.

Standard Seven. Local health and social care communities should prevent suicides by promoting mental health for all working with individuals and communities

The National Service Framework for Children, Young People and Maternity Services 2004

Standard One. Promoting Health and well being identifying needs and intervening early. The health and well being of all children and young people is promoted and delivered through a coordinated programme of action, including prevention and early intervention where possible to ensure long term gain, led by the NHS in partnership with local authorities.

Standard Eight. Disabled Children and Young People and those with Complex Needs. Children and young people who are disabled or who have complex health needs receive co-ordinated high quality child and family centred services, which are based on assessed needs, which promote social inclusion and where possible which enable them and their families to live ordinary lives.

Standard Nine. The Mental health and Psychological well being of Children and Young People. All children and young people from birth to their eighteenth birthday who have mental health problems and disorders, have access to timely integrated high quality multidisciplinary mental health services to ensure effective assessment treatment and support for them and their families

Choosing Health 2004

Choosing Health commits to:

'Take forward work on developing a whole system approach to tackling inequalities in the mental health care system experienced by people from minority Black and minority ethnic communities.'

In the context of Choosing Health the Spending Review of 2004 identified the Public Service Agreement Target to substantially reduce mortality rates by 2010 from suicide and undetermined injury by at least 20%. To address the targets in the areas experiencing the greatest health inequalities the Spearhead Group of Local Authorities and Primary Care Trusts were identified to pilot projects in relation to the Public Sector Agreement Targets (PSAs).

Every Child Matters 2003

Every Child Matters is focussed around ensuring specific outcomes for children and young people. The 'be healthy' outcome includes specifically:

- Children and Young people are mentally and emotionally healthy
- Children and Young people are sexually healthy

Youth Matters 2005

Youth Matters adheres to the same outcomes framework of Every Child Matters. Mirroring the same points above.

Delivering Race Equality in Mental Health 2005

Delivering Race Equality in Mental Health Care' commits the Department of Health by 2010 to the following:

- A more balanced range of effective therapies such as peer support services and psychotherapeutic and counselling treatments ... that are culturally appropriate
- A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and the planning and provision of services; and
- A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities

Through the DRE the Department of Health makes PCTs, and Local Health Authorities responsible for the 'training in religious cultural and linguistic requirements of people of BME groups.

The social context of the Muslim Community

Muslims are the second largest religious group (1.6 million)¹ in Britain, comprising three per cent of the total population. The community comprises a wide range of ethnic sub-groups including 610,000 Pakistanis / Kashmiris, 200,000 Bangladeshis, 160,000 Indians, 350,000 Arabs and Africans and 180,000 from other backgrounds (e.g. Kurds, Kosovans). Just under half (46 per cent) of those in Britain were born in the UK. More than half of Britain's Muslims are under 25 and a third under 16 years of age.

38 per cent of Muslims live in London; the regions with the next biggest shares are the West Midlands (14 per cent), the North West (13 per cent) and Yorkshire and the Humber (12 per cent). Within these regions Muslims tend to be spatially concentrated in local authority districts, the greatest being Tower Hamlets in East London with 71,000 (36 per cent). Muslims tend to be disproportionately represented in the most deprived urban communities. Further these particular communities appear to have clear ethnic profiles; almost 70 per cent of Bangladeshis and Pakistanis in Britain are estimated to be living in poverty.

Above ethnic groups can be further sub divided into e.g. Sylheti, Kashmiri, Northwest frontier Pakistan (Pathan), Moroccan, Egyptian Somali in order to see where there are any distinctive patterns with regard to socio economic deprivation indices, relationship to point of origin. This level of interrogation is necessary to identify these patterns, identify group needs and design interventions.

Identity

Though the issue of identity has not been researched across the Muslim community approximately 50% of Muslims are under the age of 25 and for many of these young Muslims, 'religion' is a greater factor in the framing of identity than 'ethnicity'. How it is viewed can affect approach and impact upon intervention². The affect/effect/determinant perspective towards Islam in young peoples' lives by policy makers and practitioners though appearing insignificant has significant practice implications.

Islam is widely understood as the second most important issue after family in the issues listed as that most affecting the lives of Muslims. Alongside family it plays an important part in shaping sense of self and society (it is a foundation for and a tool of engagement).

'Among all age groups a clear majority identify themselves as 'British Muslims' rather than as 'Muslims' only. Muslims under 35

¹ All Demographic data in this section is from either the 2001 census or the Office for National Statistics unless specified otherwise.

² The Muslim Youth Work Foundation A National Strategy for Muslim Youth work

years of age prefer to identify themselves by religion alone more than those aged 35 or over it is little surprise given the attention to this aspect of their identity. Muslim identities are complex and dynamic, composed of different factors that may appear alien to the outsider in their ability generate connections and relationships. These are manifested in single, multiple or hybridised identities with new, old and reworked forms of religious and cultural expression. Simplistic characteristics are inaccurate, unhelpful and misleading. This is most clearly apparent in the identities of third generation Muslim young people who through interactions across communities must form multiple or hybrid identities to interact effectively across cultures’.

Dr M Khan Muslim Youth Work Foundation 2006

Within the wider context of faith both established and emergent Muslim sub-communities will often develop along the lines of either ethnicity or in terms of differences in religious law and or practice. In part due to the ‘simple’ historic nature of ethnic monitoring subtle nuances such as the differences within Muslims communities of Pakistani and Kashmiri or the distinctions between Muslim Southern Nigerian and Christian Southern Nigerian communities are lost with small and emergent communities developing cultures and identities which are distinct but relatively unknown to service providers.

Despite the consideration given to the phenomena of the ‘Muslim ghetto’ Cattle 2001 as a root cause for Muslim alienation comparatively little attention is paid to the rising levels of Islamophobia. This latent anti-Muslim sentiment makes living in some communities a dangerous and frightening proposition for Muslim families. The community engagement research project Aap Ki Awwaz in a study of 147 Muslims views of mental health and mental health services found that 61% of those interviewed believed that the portrayal of Muslims in the media since 9/11 affected the mental health of the community³. Both of these factors relate to social exclusion a stressor known to have impact on mental health.

Employment and Education

Muslims have the highest unemployment rate of any religious group in Britain (office of National Statistics). In 2003-4 they had the highest male (14 per cent) and female (15 per cent) unemployment rates. Muslims aged 16-24 have the highest unemployment rates of all (22 per cent), being twice as likely as their peers in other religious groups to be unemployed. 35 per cent of Muslim households have no adults in employment. Of Muslim men in work, they are the least likely to be working in professional or managerial occupations and the most likely to be in low skilled jobs. Almost a third (31 per cent) of Muslims of working

³ Rethink ‘Our Voice’ the Pakistani community’s view of mental health and mental health services in Birmingham. Report from the Aap Ki Awaaz Project 2007.

age have no qualifications, which is more than twice the proportion from the next religious group. Black and minority ethnic groups are expected to account for half the growth in the country's population of working age by 2010.

Mismatch or discontinuity of values and practices between the school and home environment place psychological strains on Asian children and young people specifically girls in excess of those experienced by white counterparts causing tension and anxiety. Ghuman 2005 and Basit 1997 described the situation of groups of Muslim girls in a London school where it was found that many teachers were unintentionally discriminating. Muslim values were misinterpreted for example respectfulness was seen as submissiveness, and modesty was construed as traditionalism. Ghuman notes that though most Asian girls learn to cope with this, a minority suffer from psychosomatic illnesses, depression or anxiety.

Muslims are also the least likely to have degrees. Their academic (under) achievement is compounded by the high incidence of factors known to adversely affect it these include – low incomes, unemployment, lack of proficiency in English. One third of Muslims (34 per cent) are aged under 16 compared with one fifth of the population as a whole. 36 per cent of Pakistani boys gained five or more good GCSEs compared with 57 per cent of White British boys and 14 per cent of graduates of Pakistani origin are unemployed compared with 6 per cent of White British graduates.

In exploring the social context of Muslim communities in this way it is apparent that irrespective of factors specifically derived from their faith or cultural identity Muslims often experience the impact of social exclusion. Pre-formulated views regarding being Muslim do not in them selves clarify the root cause of social problems or the related concerns regarding mental health. 'Muslimness' is not the only enquiry line that should be used to investigate or analyse the above; gender, class, ethnicity, disability, sexuality or whether one is newly arrived are also necessary tools to differentiate and analyse Muslim communities.

Defining or identifying need

Defining the nature and level of need in Muslim communities in the UK in regards to mental health is difficult in part due to the lack of data collected in relation to ethnic minority mental health, mental health by faith or specifically Muslim mental health.

Quantitative indicators of need

However had there not been indication of a disproportionate issue of mental health amongst Muslims it would still be important to consider the impact of the fact that 1 in 4 British adults experience at least one diagnosable mental health problem in any one year The Office for National Statistics Psychiatric Morbidity report (2001) on the UK's second largest faith community. In addition to the

estimated baseline for mental health problems that can be derived from the work of Singleton et al, quantitative data exists that indicates that Muslim communities suffer from poor physical health, deprivation and social exclusion, factors which are known to relate to poor mental health.

- Poor Physical Health. There is evidence in regard to ethnic communities with significant Muslim populations. Bangladeshi and Pakistani communities have disproportionate level of physical ill health. Along with Caribbean, Pakistani and Bangladeshi people had worse health than Indians Africans or white people. Modood & Berthoud 1997.
- Deprivation. Muslim men of Pakistani and Bangladeshi origin are disproportionately unemployed compared to other Asians. Even after allowances for education and residential area, Pakistani Muslims are three times more likely to be jobless than Hindus are. Indian Muslims are twice as likely to be unemployed than Indian Hindus are. After adjustments for training and family circumstances, ethnic minority men earn less than white workers. For women the picture is different. Pakistani women earn £34 a week less than white women, but Indian and Caribbean women earn more - £14 and £30 respectively. Performance & Innovation Unit, Cabinet Office 2002.
- Social Exclusion and Mental Health. High risk groups for the prevalence of neurotic disorders include the unemployed the economically inactive people with 2 or more physical illnesses D Meltzer et al 2004. Ethnicity is also directly cited as a factor related to social exclusion and mental illness. People from ethnic minority groups are 6 times more likely to be detained under the mental health act than white people B Audin I and P Lelliot Age 2003. Specifically ethnic communities with significant Muslim communities show greater propensities for poor mental health. Common mental health problems are fairly similar across ethnic groups although rates increase in relation to Pakistani women. K Spronston and J Nazroo 2002.

The above external factors though significant do not solely account for the nature of mental health concerns Muslim communities. The Oppressed Voices Community Engagement Research Report on the effects of domestic violence for South Asian Women in a sample of predominantly Sikh and Muslim women found that 55% percent of their sample had experienced domestic violence. Across the sample 73 percent were of the opinion that in a situation of domestic violence the shame (Sharam) related to domestic violence would prevent them from seeking help with a considerable proportion of those who had experienced domestic violence have not consulted their GP. This was despite the fact that the most common effects of domestic violence reported related to mental well-being. This supports the previous findings of Kumar et al in their study Domestic Violence and its mental health correlates of 2005 which noted a clear correlation between domestic violence and mental health problems in regards to the

experience of domestic violence the observation of it or the previous experience of it in childhood. Within the Oppressed Voices study it is probable that of its 55% who had experienced domestic violence 100% had experienced depression, with 60% having experienced suicidal thoughts and 33% having attempted suicide.

Qualitative indicators of need

In the report Providing Faith and Culturally Sensitive Support Services to Young Muslims (Malik Shaikh and Suleyman 2007) The Muslim Youth Helpline in a quantitative and qualitative analysis of its service identified five predominant concerns and five emergent themes. The main concerns identified by clients in order of significance were:

- Relationships
- Mental health
- Religion
- Offending behaviour
- Sexuality and Sexual health

This was within a sample of approximately 1400 enquires with a gender breakdown of where data was available of 49% female and 38% males. When assessed by gender the five most significant concerns for female service users were relationships, mental health, religion, education and abuse; and for male service users relationships, offending behaviour, mental health and sexuality. Further analysis of the data revealed that in relation to mental health the primary issues were anxiety and distress depression self harm and suicidal feeling with such feelings being reported in 17% of the enquires where mental health was the main concern. The complexity of the mental health concerns relating to Muslim young people within this study however must be fully considered in the context of the other major concerns raised by clients and the way that these concerns often did not occur in isolation. Primary concerns regarding relationships for example though they may have sub themes relating to marriage and divorce, boy girl relationships, family pressures relationships with parents or forced marriage were noted to link to other secondary concerns within the reports qualitative analysis.

Of the emergent themes it is important to not the interrelationship between identity and faith as indicated above and within the theme of identity and 'muslimness'. This has positive implications when young people see Islam and identity as part of a dynamic organic process where both are created as a living reality part in relation to the current context. There are however themes of recognition and acceptance and marginality which may undermine the self esteem of Muslim young people in building a context for their self worth within the mainstream society as well as the Muslim community. The Young Minds Research Report Minority Voices Street et al (2005) notes the concerns of CAMHS staff in relation to the lack of understanding of complexities such as these and in general issues of faith and culture when working across ethnic minority communities.

Understanding the diverse nature mental health and Muslim communities is compounded notably by some of their shared experiences. A recent qualitative study by Phillimore, Ergün, Goodson, Hennessy, and the BNCN Community Researchers of refugee mental health (2007) analysed data from a sample of refugees including a significant proportion of Afghani, Iraqi, Kurdistani, Iranian Somali, and Sudanese. Within this study factors identified as impacting on mental health included:

- Past experience of war, persecution, torture, sexual violence and flight
- Concern regarding continuing political problems in their country of origin
- The asylum system
- Discrimination, bullying and harassment
- Isolation loss and separation
- Culture shock
- Qat use among Somali men
- The impact of Chemical warfare on the Kurdish community
- Being a Muslim in British society in the current political situation

A common experience for those who had seen a GP was the use of medication as the main form of treatment where treatment was accessed. Others were put off by long waiting lists for treatment; women in particular were reluctant to discuss their mental health or experiences with white male GPs. In this context 30% of the participants in the study found current mental health provision poor. This tallies with findings in the Aap Ki Awaaz report that found that 30% of participants again found current mental health provision poor.

Another recent consultancy report by Ashram Housing Association regarding South Asian communities in addition to identifying to identifying substance misuse, depression, suicide and dual diagnosis in relation to Asian men, the relationship between domestic violence and mental health problems in women and children the report identifies many of the difficulties that young people feel in relation to their experience of cultural conflict between modern UK society and traditional values. Participants within this consultancy were of the opinion that within their locality services for Asian women were varied with some examples of good practice but services for men and children and young people were inadequate. However their was a consensus view that in both the statutory and voluntary sectors training needed to be improved clinically and culturally. One concern raised within this study was the apparent lack of professional response to mental health problems in children where there was no evidence of direct risk but there was evidence of mental health problems and or the missing of developmental milestones.

In this scoping report in order to understand the context of mental health problems in Muslim communities the author has additionally surveyed service providers, Imams and voluntary organisations in the community to scope the

nature and degree of need.

In this context it is possible to understand some of the complexity of the presentation of Muslim Mental Health, through various agencies different aspects of the Muslim communities present different aspects of mental distress or illness. Some present case scenarios related to common social causes or life events in the context of recognisable mental illnesses, others present symptoms of mental distress or illness specific to the experience of the Muslim community. This variation relates to issues of access and in part reflects the clients the service is in contact with and the trust the clients have in the service.

Though some of these profiles of client need have overlapped the differences reflect the complexity of relationship between felt need (that is the mental health need experienced by the individual), expressed need (the mental health need as expressed by the individual) and normative need (the mental health need as understood by the professional) Common mental health related concerns discussed by interviewees included:

- anxiety (including OCD and PTSD) and depression,
- ADHD and apparent conduct disorders
- substance misuse, alcoholism and gambling,
- issues regarding identity, relationships and psychosexual problems,
- domestic violence (both in relation to the perpetration of and the experience of) and
- religious delusional behaviour.

In addition there was concern regarding severe mental illness in the community. As well as concerns raised regarding a wider discourse in relation to mental distress in the community the Muslim including the questions of whether or not Muslims somatise mental distress or experience distress in a different way due to their own faith based codification, understandings of health and well being, the meaning of mental distress or illness within Islam and the language in which these understandings are conveyed, and the relationship between irregular religious practice and mental health distress or ill health. Issues of the language in which mental health is discussed within the Muslim community are of course more complex due to the commonly sited concerns regarding working with interpreters or with clients whose are not fluent in English.

An Nisa a women's organisation has previously had a significant role in developing Islamic counselling training and still refers clients to other services were of the opinion that Muslims needs are the same as any other community they need access to appropriate mental health care services. However their concern was that the Muslim community has been neglected in relation to mental health provision and has experienced a range of forms of mental distress most of which goes unnoticed by the service providers Muslims said to have the same

levels of need related to social experience as other communities shown in ways that are specific to the faith and cultural identities of the communities. This requires specific responses that relate to their beliefs, the way they see themselves and the world.

This situation of neglect was reported to be further reinforced in relation to young people particularly men in emergent Muslim communities and established communities in areas of relative poverty. Here concerns were raised that apparent social problems including poor educational performance and street crime *may* in cases be related to psychological problems such as ADHD. ADHD is one of a number of psychological problems, which may develop from emotional trauma, which can be linked to such common experiences in these communities as being an unaccompanied minor asylum seeker, wider issues of migration and forced migration or poverty.

Shereefa Fulat of the Muslim Youth Helpline raised important concerns regarding a lack of awareness in relation to mental health or illness and hence a difficulty for individuals to realise the need to seek help. She discussed an apparent lack of vocabulary presents a barrier to seeking help or even conceptualising illness or imbalance. This is less the case for young people however there are related difficulties for young people, as they are not empowered by the wider community to discuss these issues.

Drs Salim and Skinner reported work across a range of presentations from matters of Islamic law and basic education, matters of mental distress anxiety or depression to issues of jinn possession. In addition to the above complex issues of faith and identity, relationships and sexuality, gender based violence; abuse - both physical and sexual and substance misuse related psychotic episodes have been identified in relation to some Muslim youth in work carried out by Sabnum Dharamsi of Stephen Maynard & Associates and Dr Malik. However the extent of these issues in the Muslim community is not known as a whole, or the distribution.

A number of interviewees were of the opinion that there is a need for faith and culturally sensitive services within the NHS mental health services in general were seen to be ineffective needed to work in conjunction with services developed in the community. Training is not developed and although people try to address issues within diversity training this is often insufficient and ill conceived in relation to Muslim communities. Dr Skinner stated that the psyche of Muslims due to the nature of their 'Islamic' cognitive schema (mental structures that represent aspects of the world) is resilient and more able to integrate difficult life events than those of the general public. In this context he disputes the value mental health service interventions, which fail to address the spiritual dynamic in addition to the culturally specific nature of the presentation of distress or illness. In the context of Islamic thought he argued that the 'mental distress' is often a process of growth, which is then inappropriately labelled

through a problem focussed model of mental illness. This perspective was echoed by Sabnum Dharamsi whose opinion was that the discourse on Muslim mental illness needed to be replaced by wider definitions of mental health and well-being.

Dr Malik was concerned that the more alienated communities are the more unsafe it feels for them to interact in the mainstream. Having noted the fact that since 9/11, clients started specifically asking for a Muslim therapist or counsellor her concern was that if the political context is one in which Islam is denigrated 'professionals' may already have assumptions about Islam being oppressive. Hence it is unlikely that they will be able to open up meaning to the client in a way that will fit with who that person is. It becomes a process of defining meanings in a way in which the person is faced with a dilemma of falling into one system or another.

From Dr Malik's perspective, clients often experience professionals' negative conceptions of Islamic practice as well as negative assumptions within Muslim communities regarding mental health services. Muslims experiencing problems find themselves stuck between the two.

“How do you define who you are when your identity and values are neither replicated or confirmed in the mainstream of society but demonised so how do you position yourself when the mainstream see you as bad while in your community the mainstream values are seen as bad. With this constant simplistic notion of good bad, in a way that you go from one to the other.”

This stress of interacting with opposing belief systems was seen as a recurring theme. It was felt that Muslim communities act as part of an integrated global community responding as a whole to significant experiences of parts of it nationally or internationally. Here the community in dealing with images and messages on a constant basis that are antagonistic to its sense of self worth, is experiencing increased levels of anxiety fear and anger. Individuals in the communities are polarising between their core beliefs regarding faith and cultural identity and modernity. It was reported that these reactions are taking place at all ages in all contexts including the school, the family, the mosque and work environment.

In this environment of increasing alienation and polarisation one interviewee had observed through work with some Muslim families very high levels of hostility in relation to the host community. The results of this were incidents of adult male family members indoctrinating their pre-school age sons in faith based hatred.

Organisations such as The Muslim Women's Helpline, The Muslim Youth Helpline, The Arabic Counselling Service and Sakinah reported a variety of

problems resultant from social causes including depression, anxiety, relationships, family / marital issues including adultery or divorce, and gender based violence (domestic violence⁴) and sexual abuse with a range of severity in terms of the experience of the client. Many of these incidents were in relation to female clients.

Imams interviewed in two different cities gave further evidence of the problems experienced by women with regards to marriage and relationships citing cases of anxiety and depression, the need for support for women clients in relation to the husbands addictive behaviour (alcohol, drugs or gambling), domestic violence, the threat of violence, or honour crimes experienced both by women in marriages or in relationships outside of marriage. One Imam spoke in detail of the difficulties experienced by young women in regards to relationships or abuse indicating the way that emotional distress and suffering of the individual in the family can often be weighted against the honour of the family. Though this particular Imam was sort out by a number of young people for counsel or support, he himself felt unsupported by the NHS or the Muslim community. In contrast an alternative perspective given by a second Imam was one in which such issues were not discussed but were often the reason cited in divorces, which were seen to be at a high monthly rate. Here the Imam was concerned that though these issues were tacitly acknowledged, there were no resources for the individuals concerned to receive the psychological support necessary. A third Imam spoke of cases of extreme religious behaviour that lacked (from the perspective of the observer) an apparent logic, and the issue of determining if such behaviour was indicative of mental illness. A number of additional Imams raised concern regarding the impact of substance misuse within Muslim communities across wide age range and relating to a variety of substances.

An implicit question raised by the discussion with help lines, Imams, and domestic violence voluntary organisations in relation to domestic violence relates to the people who carry out these acts of violence. Very little is known about the mental health of these individuals who are at present very hard to reach. It is not known if these individuals make up a homogenous group or if there are common themes in relation to their actions.

This 'possible client group' is known of through various services though the size of the group cannot be estimated due to issues of reporting within some communities that have a history of presenting the woman within the family as the problem. There are however indications of a very hard to reach client group predominantly male. There are speculations that this pattern of behaviour and the related client group represent a generational a response to the difficulty to adapt to the 'liberal' environment of modernity in Britain, within Muslim

⁴ At the time of completing this study 50% of the Women in one Asian Women's Mental Health Sheltered Accommodation Centre were victims of domestic violence.

communities attempting to maintain their 'cultural' integrity. This response can be part of a process in which isolated from their original cultural context and challenged by their current one individuals and their social norms or practices become rigid and defensive. There are other speculations that for some individuals perpetration of domestic violence is a result of a personality disorder, which is in itself based on emotional trauma at an early age.

Though there is a discourse in relation to Muslim women and mental health Muslim men in general were considered hard to reach in regards to this subject. Community specific issues and behaviours further complicated this. Somali volunteers spoke of the high levels of alienation among young Somali males many of whom having left Somalia in their earlier childhood were dislocated having spent the majority of their lives as refugees between various European states. It is possible that in other emergent Muslim communities that have experienced traumatic changes the mental health issues of Muslim men may not be recognised.

Assessment of the qualitative data indicates a variety of key groups for understanding mental health issues and related needs within Muslim communities in the UK i.e.:

- Muslim Men
- Muslim Women
- Muslim Young people and children
- Refugees

Each of these groups has its related mental health concerns and service issues.

Literature review

It is important to set a framework for the discussion of models of practice in relation to Muslim mental health. Much of the current professional discourse regarding the relationship between Islam and Mental health originates from the 1979 publication by Badri MB *The Dilemma of Muslim Psychologist*. This text sets out a set of criteria for the development of an empirical psychology in terms of its procedures but one that is informed by Islamic values and principles. This position has been countered by other psychologists such as Frager who supports a more phenomenological approach arguing for a pre-existent Islamic model of the self and psychology in the body of work of tassaouf (the sufi 'gnostic' teachings within Islam) and nafsiyat (the science of the self). Frager's position being influenced by the work of Haeri and Haeri (see page 16). This discourse is related to the wider discussion amongst professionals, which is still primarily concerned with what might be appropriate models of working.

There are also the perspectives of Alims, (Islamic theologians with expertise in Islamic law) Hakims, (philosopher /physicians) and *Sufi* Shaykhs (teachers of

the gnostic traditions of the spiritual development – see above). It is important to note that these roles or positions are not necessarily mutually exclusive. There are different ways of thinking about Islamic models these models may in addition overlap. These differences can be seen as reflecting differences in practice rather than confusions in relation to one way of working.

This does raise issues though in relation to the inclusively or the holistic representation of one model of Islamic practice in relation to mental health, rather the differences in perspective reflect the potential sophistication of Islamic mental health practice.

Based on teaching of the science of the self in her 2000 paper Yaqoob constructs an uncomplicated therapeutic process based principally on the Islamic concept of life being in a state of transit from Allah to Allah. This sets in context the understanding of life events enabling the client to integrate psychological or emotional difficulties within a spiritual framework, which holds them in a learning context or a process of self-development.

In his 1989 paper Dr Skinner (referencing Dr Khan) presents one of the earliest therapeutic models of the self one of a series of proposed paradigms in Islamic Psychology. Here he presents a model of the self, which is holistic (a common thread in Islamic thought) seeing the interrelation between the ruh (the soul), the heart (the interconnection between the soul and the body) the aql (the intellect) and the nafs (the drives) coming together through the dhameer (consciousness).

The quality of the heart is affected by the spiritual practises of the remembrance of Allah, (living in a God conscious manner) such as dihr (active remembrance though individual reflection or group process) or Ibadat (the active service of God through the action of ever day life including worship and service of others). The Aql is affected by external factors such as education or environment e.g. social conditioning. The nafs are again influenced by social conditions, as well as the body diet etc. This brings in the element of soma as within this model the body of the self is seen as significant in terms of psychological emotional or physical presentation of the human response to life experience. The model is presented as a developmental model with three stages of self-development.

Dr Khan in his 1991 paper on tibb medicine identified the Islamic tradition of unity in the assessment and treatment of the self, identifying the holistic nature of Islamic health and hence mental health.

Shaykh F Haeri's in his 1989 book compiles a series of models and interrelated theories on the nature of the self and its development from the teachings of Sufism in Islam. To frame these traditions in an applicable model Haeri groups the psychological process of development in terms of a series of stages of development of the self in time space these stages are inner dependence (in the womb), outer dependence (childhood), interdependence (adolescence and

adulthood to the age of approximately 40 50), Inner reliance (old age). In addition he presents a values based model of working with mental and emotional problems. In doing this Haeri draws on the sufi traditions such as the model of virtues and related vices, the seven stage developmental model of the nafs, the teachings regarding the inner and outer senses and the grid of eight analysis of the significance or interpretation of experience. In bringing together a series of different conceptions Haeri presents a related but different model of the self. Both Shaykh Haeri and Dr Skinner see the heart as the abode of the ruh and hence the place where the fitra or original coding of how to live in balance with the creator and creation abides. Both see the Aql as the seat of intellect. In addition Haeri describes the nature of the inner senses and their relationship with the outer senses (taste touch etc). Haeri in describing the interaction of inner and outer senses presents means of understanding the way that psychological processes respond to sense data presented. The main distinction between Haeri and Skinner is in relation to the nafs, which Skinner sees as the drives and Haeri as the composite self in a state of development from the base to the sublime.

Shaykh F Haeri and A Haeri unpublished work (1989 later published with permission in a paper by Maynard 1998) describe a model of the self in which the heart is presented as the seat of the soul and fitra, The intellect is presented as subordinate to the heart as the meeting point of the inner and outer senses with a roles more related to the existential aspects of living. These organs interact with the drives of attraction and repulsion and though this interaction facilitates the development over time of the positive and negative qualities of repeated action and character of the individual (the virtues and vices). The inner drives are monitored by the combined aspects of the self the monitor and witness which enable the self to see itself and change its internal responses or processes.

Over time the models of Skinner and Haeri & Haeri have developed to a degree in relation to each other. Currently the Haeri model is presented as a sophisticated spiritual and psychological developmental model of self-knowledge⁵.

The work of Dr Khan, Dr Skinner and Shaykh Haeri & Haeri are also linked in terms of a philosophical similarity. A central tenant in these Islamic models is that they are models of well-being rather than models of mental ill health. Dr Skinner's work addresses this partly through a critique of psychiatry and mental health in his 2005 paper.

Dharamsi 1996 (unpublished) presented a model of the actual process of Islamic counselling for the first time linking the Islamic understanding of the self to skills to be developed and practiced by the Islamic counsellor. This process model when linked to the Haeri and Haeri model of the self provides core components for an Islamic counselling intervention. Maynard in his 1998 and 2002 papers

⁵. Presented in the internet based Academy of Self Knowledge

presents the application of the Haeri and Dharamsi models in relation to the Islamic counselling process. In the Maynard and et al paper of 2001 he sets out the assumptions of Islamic counselling and its related model of the self, he identifies the Islamic therapeutic relationship (latter referenced by Dr Inayat) and codifies the disciplines or standards of Islamic counselling in relation to the CPCAB award body model and hence in relation to agreed standards of competence.

Dr Malik in her 2006 paper through concentrating on process explores the internalisation of multiple identities in coping with the conflicting expectations of traditional Muslim communities and modernity. Here she explores the use of the therapeutic space as a means of clarifying the personal, the political and the spiritual. She argues that matrices of Muslim multiple identities are constructed in the context of simplistic dichotomies of good or bad. In this context she advocates the provision of safe spaces that enable open dialogue and exploration. In addition she advocates the use of Islamic story telling as a therapeutic tool within this process.

In addition to the above texts on theoretical models there are a selection of papers by a number of writers on the subject of Islamic approaches to mental health. Dr Inayat, drawing on the combined work of Haeri, Haeri, Dharamsi and Maynard explored the relationship between integrative therapy and Islamic counselling. Papers by Hoseini, (2001) Badri (2000) Rashid (2000) and Magid all advocate the positive impact of working in a way that is understanding of the cultural and religious impact of Islam within the therapeutic or counselling space. Shaykh in her review of 2006 documents much of this work. Though they do not put forward a specific therapeutic model emphasis is placed on the natural order of living in an Islamic way, this in the case of Magid then defines counselling as a process of advising people how to live in accordance with shariah.

Bobat in his 2001 qualitative study notes the positive impact of mosque attendance by Muslims men living with long-term mental health problems. In particular he identifies the therapeutic effects within his sample group of ablution and prayer.

The research of Zaidi (2006) assesses the interventions carried out by Imams when presented with Psychological distress or mental illness. Her study identifies the traditional route taken by a number of Muslims in regards to psychological problems and finds that in her sample Imams were better able to assess the difference between spiritual and psychological problems than health professionals.

Khalifa and Hardie 2005 In their paper on jinn possession identify the difficulties in diagnosis and treatment that occur in the context of the relationship between belief systems both professional and community. In its presentation of two cases one successfully treated by each perspective and following an unsuccessful

intervention from the other. The paper raises questions regarding case management in the context of traditional medical interventions and faith based cultural beliefs. The paper further calls for more research clarifying the relationship between explanatory models in mental health and Islam.

With regards to the theoretical models of Islamic approaches to mental health there appear to be a number of clear identifiable streams of thought, the Islamic shariah school of thought as indicated by writers such as Magid, the work of Badri based on the development of an empirical Islamic psychology, the work of Khan and Skinner within the context of tibb relating to both the physical and mental health aspects of the whole person and work of Haeri, Haeri, Dharamsi and Maynard, and their related colleagues such as Frager and students such as Yaqoob and Inayat which though acknowledging the interrelated nature of physical health in their work emphasise spiritual and psychological well being. Both the works of Skinner Haeri et al in addition to developing a therapeutic perspective for working with mental health also have been instrumental in the development frameworks for the development of Islamic or spiritual psychology.⁶

Theoretical models of working with Muslims communities

In scoping the field a variety of frameworks are currently being used for working with Muslim communities, which have been developed in addition to current mainstream provision. These models by and large have been developed through the work of:

- Muslim health professionals
- Muslims scholars and specifically hakims, (theologians with specific knowledge of Islamic medicine 'tibb') or Shayouk (Shaykhs of the sufi traditions Islamic teachers of the science of the self – nafsiyat)
- Muslim Health activists

Though not universally the case this work has often taken place through a process of cross-pollination where in areas of knowledge have been shared across the above groups.

A variety of approaches have been adopted to the development of theoretical models and services, which can be broadly categorised as:

- Faith based mental health promotion
- Participant led services
- Faith based and culturally sensitive support and advocacy
- Culturally sensitive mainstream counselling or faith sensitive counselling
- Islamic counselling

⁶ This includes the work of Frager and A Haeri in transpersonal psychology, and the work of F Haeri in the Academy of Self Knowledge.

- Islamic psychotherapy

Broad themes that assist in the description of the distinctions and commonalities in the above theoretical categorisations are:

- Whether or not the model is responsive to the cultural identity or experience of Muslims
- Whether or not the model is primarily faith based
- To what extent the model integrates contemporary mental health paradigms
- To what extent the model is either community or user driven

Prior to exposition on the current models of practice it is worth considering that in relation to faith based models the source material may be based upon either the original writing of the Quran and the Hadith written relating to the Prophet Mohammed, or on the above source material and the works of theologians from the various schools of Islamic thought.

Faith based mental health promotion

This approach to mental health promotion can be seen in the partnership work that has taken place between Stephen Maynard & Associates, rethink, Green Lane Mosque, Birmingham and Solihull Mental Health Trust and CSIP West Midlands. The programme of mental health promotion was designed to incorporate knowledge from both the mental health field and Islamic theology and build the basis of a shared language for understanding mental ill health and distress that can be used with Imams and Masjid teachers to enable them to promote mental health through the wider Muslim community. The aims of the programme included providing Imams, and madrassa teachers with a programme of mental health training that is both spiritually and culturally competent, and increasing mental health awareness among Imams, and madrassa teachers in the area. Hence enabling them to champion mental health promotion within the mosque. Outcomes of the programme included the development of integrated spiritual and mental health approaches by participating Imams leading to potential innovations in practice specifically in relation to joint work between Imams and mental health professionals. The theoretical framework of this programme is an adaptation of both mental health promotion and the Islamic model of the self as referred to latter in this paper in relation to Islamic counselling. Through working in partnership Imams were recruited for major mosques in Birmingham and the West Midlands with the object on completion of the 12 session programme Imams and Masjid teachers with the support of CDWs to initiate basic mental health promotion programmes through their mosques and work in closer partnership with existing mental health services.

Participant led services

Sharing Voices

This model of work is exemplified in the Bradford Sharing Voices Project. Though this project is not Muslim specific it provides a wealth of data on ways of working within diverse communities with large Muslims sub groups from a variety of ethnic origins. A key aspect of the approach was the active participation of the PCT in the development of partnership work with the local communities and the identification and empowerment of local Muslim health activists through the use of a community development strategy. In the process of engagement the community development worker developed a dialogue within the community relating to wider definitions of mental health encompassing as a key concept mental distress. In so doing the development of an approach to working with Muslim communities reframed mental illness and placed the emphasis on mental health professionals to work with the understanding of mental health of the client hence taking into consideration the local perspective that psychiatric models were antithetical to Islamic understandings of the life process.

The process of enabling people to discuss mental health in their own terms was in itself found to be empowering. This was assisted through the provision of gender specific space for discussion, and was found to have positive impact for both men and women. Muslims were able to engage in dialogue regarding mental health, mental distress partner problems and a variety of social issues that impact on psychological health. What was critically important for them was a space where they could talk and explore their experiences in their religious framework. Story telling was used as a tool for exploration of issues relating to mental health. People started learning more about their faith; this empowered them to create change in a meaningful context. This has resulted in a men's dihr circle where dihr (the process of the remembrance of God) a spiritual process was engaged in for therapeutic value and the Jinn project, a group specifically for men concerned regarding possible possession by spirits. A men's fitness club has been developed along side as a less contemplative means of developing mental health. With regards to Muslim women hamdard (an Urdu word meaning support) was developed, a once a week support group in which women could talk openly about the pressures and tensions they experienced hence reducing the risk of hospitalisation or crisis. The women came from a variety of ethnic communities but came together as Muslim women. Through the exploration of their commonalities and differences this enabled them to reinterpret their experiences and decipher what was distinctly Islamic from what was cultural. The shared experience of hamdard provided women with a space to share in confidence issues such as depression or oppression, gain new skills and support and enjoy themselves within their shared identity.

Sharing Voices is not a specific Muslim focussed project the model is community developmental with a significant theme of action research. This supports the initiative of credible community leaders (as opposed to those who claim to speak

for the community in peer led initiatives as well as assessing these initiatives in relation to the participants' experience of them. This results in different ways of codifying experience of mental health or distress, which are more person centred than the classical diagnostic frameworks. Hence assessment is from the client's perspective in a predominantly Muslim community, involving "unpacking" the meaning of the client's situation or experience. This cannot be divorced from its social context. Here it has been found that work with Muslims is more effective when it explores their understanding through faith to find solutions through faith.

Imam / mosque based counselling services

In the absence of accessible appropriate mental health services some Muslims turn to the traditional resource of the Imam for guidance. However as indicated by imams interviewed for those Imams who provide support in the community in relation to mental health as for those voluntary agencies there are questions regarding support, supervision, skills and competence indicating the potential role statutory services could play in partnership with community provision. Further some Muslims find Imams inappropriate to their needs because of concerns regarding confidentiality or questions of competence to explore issues therapeutically

Faith and culturally sensitive support and advocacy

The Muslim Youth Helpline

An example of this model of work is provided through The Muslim Youth Helpline. The Helpline provides a telephone and internet based Faith and culturally sensitive peer support service. Here support is translated widely as possible in terms of it being a client-led service, if the client needs to be listened to needs referral, to be befriended etc. The service provides support based on shared understandings through working with volunteers of a similar profile.

In this context the faith-sensitive work is not doctrinal, not promoting Islamic practice but is understanding providing a faith-based context for the work relationship here peer support enables a greater level of empathy.

The Muslim Youth Helpline has a client life cycle, based on the experience of working with its clients. There is a seven-step route towards client progression:

- Client makes contact
- Volunteers build a relationship between the service and the client
- Client confidence grows enabling them to share confidences while volunteers work with the client building empathy
- The clients problem is discussed
- Options are explored
- The client is empowered through empathy
- Progression

In this process progression can mean the client is referred to another service or the client no longer finds the support of the service necessary. In relation to referral client-led referrals are easier it is more difficult when the helpline identifies the need for referral; partly this is about the confidentiality and support of the relationship of the client with the helpline and partly the issue of inappropriate fit of existing statutory services to the client need.

The helpline does not clearly define its model due to the service being responsive however theirs is an operational framework broadly within Islamic counselling. Their model of Islamic counselling concerns employing the principles of tolerance empathy and understanding being non-judgemental and respecting religions. This is more about the behaviour of the volunteer rather than the behaviour of the client.

In practice the volunteers at the helpline actively suspend their judgement and separate their selves from what they are dealing with in order to assist the client. 'What helps is when the volunteer sees this practically rather than as a theoretical discussion'. Everything the volunteers do is seen from the perspective of how it impacts on the client.

The helpline assess by monitoring that the client is moving forward practically or in terms of the conversation. Ultimately the aim is (though there is no expectation) for the resolution of the problem so the process is about the client making smaller transformations or achieving milestones.

Quantitative evaluation of the work is relatively easy, and is based on their database and the related statistical analysis.

Qualitative evaluation is more difficult – the helpline works towards the Telephone Helpline Associations quality standards. One of their key concerns is client dependency. Client progress is monitored on a weekly basis and action plans are developed and coordinated across volunteers.

The Muslim Youth Helpline measures impact by client numbers response and reputation. 'If people are calling we must be doing something right'.

The work of the Muslim Youth helpline in defining its theoretical model is ongoing. Currently the Helpline is carrying out a research programme analysing data from both its volunteers and its clients to assist this. Aspects of the present theoretical model are derived from the training and supervision of Dr Rabia Malik and the training of Stephen Maynard & Associates.

Chaplaincy

An alternative example of working in a faith based culturally sensitive support and advocacy process is provided through chaplaincy. Currently Muslim chaplains are working in the health and the prison services.

Discussions within the NHS context have indicated that at present there is not a clear model of Islamic chaplaincy that is effective for male and female clients.

The service is defined as pastoral and spiritual care in hospital though the role of chaplaincy is not clearly agreed in the Muslim community or in the NHS though in one hospital more than half of the Muslims female patients in maternity and the elderly patients requested a service that was Islamic and gender based.

Operationally the service is supporting people from an Islamic framework of reference and working within the cultural perspective of the various diverse client groups relating counselling support to spirituality. The service in practice is an integration of counselling, support and advocacy befriending prayer and spiritual support.

The work is faith based (as the clients frame of reference is generally Islamic) though this may not always be explicit as this is sometimes a tacit understanding that clients expect of the chaplain.

The service works with a variety of presenting problems including common mental health problems such as depression and anxiety. However there are no identified mechanisms for referral on to other services. One hospital based chaplain raised concerns regarding the lack of clarity of the framework or model and the lack of appropriate training and supervision. In addition to the issues identified in relation to assessment and referral, the chaplain interviewed indicated that the work was as much based on previous Islamic counselling or counselling training as Muslim chaplaincy training and following employment the service was poorly supported relative to the service provided to Christian chaplains. (The interviewee had participated in and accredited counselling course and two short courses in Islamic counselling neither was accredited).

Prison chaplaincy for Muslim women presents some similar issues to those for hospital chaplains. However one significant difference was the fact that for this interviewee her training in prison chaplaincy was supported by the Islamic counselling to diploma she had previously received. Enabling her as a qualified counsellor, to work (within the limits of her situation) with problems such as depression identifying mental health problems and referring them to other prison services.

Culturally sensitive mainstream counselling & faith sensitive counselling or Muslim Counselling

As identified in the literature review there is a current discourse in relation to the primary axiom of the way that models of practice are developed in relation to the mental health needs of Muslims. This discourse responds to the apparent demands within the community:

1. That Muslims want Islamic services, which integrate and build on their understanding of the self.
2. That those different understandings of Islam (as culture, or identity or active faith) are reflected by different services.
3. That they interact with community needs resulting in a variety of perspectives of integrated practice.

Two example of services operating with either culturally sensitive or faith sensitive models are the Nafas substance misuse day programme and the Sakinah Counselling Service.

Nafas

Nafas is a substance misuse day programme providing a faith sensitive service. It provides space for clients to explore the Islamic side of their persona, should the client wish to, and provides support for this partly in recognition of the absence of any form of residential treatment where clients can go and reengage with their faith identity.

As a faith sensitive service it takes into consideration the clients' cultural beliefs and needs. Similarly to the Sharing Voices Project discussed above during the development of the project professionals in the field rather than people in the community responded negatively to the idea of the development of an Islamic service. This dialogue influenced the development of a service that was not overtly Islamic.

The team are predominantly Muslim and provide a service that is based on the Harm reduction model. The programme operates by providing an environment that is supportive of but not imposing, providing for example appropriate food and facilities for people to carry out their ablutions in the bathrooms. Muslims response to the service has been positive though some members of the wider community expressed a desire for an explicitly Islamic service where people could directly explore their Islamic faith as part of process of working with substance misuse.

The project has good links with the local mosques enabling clients to access that support locally. There is recognition that within the client group not every one wants an Islamic service. It is estimated that approximately 50% of clients would not like an Islamic programme.

The programme is a structured day-programme with a client group who arrive at the service mostly through self-referrals, a significant number are also referred by family members (mainly mothers).

In both the one to one and group work some of the material covered is faith related e.g. sexual behaviour values and Islam. This is at the request of the clients rather than staff motivated.

Though harm reduction does have a specific set of values that may be considered in conflict with those of Islamic shariah the perspective of the work is more towards abstinence through compassion taking as an example of this the compassion of the Prophet Mohammad.

Client assessment, supervision and outcome evaluation of the service follow the lines of standard lines of substance misuse day programmes. The Nafas programme is 12 weeks in duration.

Staff had noted positive changes in relation to general behaviour and substance misuse pattern of clients in relation to their being in a supportive Islamic environment. These include:

- Clients attending Friday jummah prayers;
- Clients increasing the regularity of their prayers;
- Clients reducing or stopping substance misuse during the month of ramadhan;
- Clients becoming drug free having completed the ramadhan fast.

In addition Nafas has developed a programme of training Imams in substance misuse to tier one, enabling them carry out initial assessments and referrals.

Sakinah

Sakinah is a counselling service which grew out of a project of ethnic minority counselling in the Kaleidoscope drug and alcohol service. The service works with a wide variety of concerns beyond substance misuse, targeting mainly the Asian community. Counsellors within the project use a variety of theoretical models including psychodynamic, humanistic and behavioural models. The service is voluntary comprising of both qualified counsellors and counsellors in training.

The focus on working with Muslims clients has been responsive to an increase in demand for related service following the events of 9/11 and 7/7 and the impact these events have had on the Asian Muslim identity.

The service having a significant number of Muslims responds to the faith based concerns of clients, working within the context of the clients understanding of their faith rather than a set Islamic model. When asked for guidance in relation to

shariah clients are referred to an appropriate Shaykh⁷. Clients find significance in the fact that the client and the counsellor share a Muslim identity. The process of building relationship with the client is about culture and faith, the counsellor sharing aspects of both with the client. “Its about the counsellors understanding of the client.” The service is well known and well regarded. Assessment and diagnosis combine both the psychotherapeutic and Islamic knowledge of the counsellors though there is not a clear framework in relation to Islamic input, which generally comes from the way the client describes their understanding of their situation. The service follows the BACP ethical framework and counsellors are supervised externally by Muslims counsellors trained in supervision.

Islamic counselling

The discourse indicated above ‘Islamic counselling’ can be construed to have a number of definitions indicating either a shariah or ‘Islamic’ based process of advice, or an alternative term for counselling performed by Muslims, or therapeutic models based on related fields of Islamic thought and psychological knowledge. Within the context of the third definition in the UK the Mohsin Institute and Stephen Maynard & Associates have developed the main areas of work in both practice and training. It is worth noting that at various times An Nisa Women’s community organisation have provided counselling services (and in conjunction with the Mohsin Institute and Stephen Maynard & Associates training). In addition the Muslim Women’s Helpline and the Arabic Counselling Service (whose services will also be reviewed below) play significant roles providing Islamic counselling in the community.

The Mohsin Institute

The work of the Mohsin Institute is based of the work of Dr Hakim Salim Khan and is derived from the teachings of ‘tibb⁸’ medicine.

The service provided is a combination of religious / educational and Islamic counselling as well as Islamic counselling training working with a variety of issues spiritual emotional and practical.

The work is seen as support and counselling, combining mainstream counselling culturally sensitive counselling and Islamic counselling. In part the rationale for this is the diversity and complexity of both Muslims and the situations they experience. “Muslims must be reached according to their state...” hence Dr Khan advocates the use of culturally sensitive counselling when the person is not clearly identifying with their deen before embarking on Islamic guidance based on faith or Islamic counselling. Here Islamic counselling is seen to be about moving between mainstream counselling to faith sensitive work and an Islamic

⁷ The term Shaykh translates as teacher and can be used in relation to a person of knowledge regarding Islamic law as well as nafsiyat or nafsiyat).

⁸ The holistic model of Islamic medicine practiced by Hakims.

perspective. Islamic Counselling is not seen as isolationist but a specialism based on a generic understanding of counselling.

Students training in Islamic counselling receive training in two levels a foundation course lasting 6 days and a diploma consisting of 6 case studies and 12 one to one sessions, plus herbal medicine and 600 clinical hours supervised practice.

The work is faith based emerging from the Islamic tradition of tibb to meet the needs of Muslims in terms of living in this context. The work is holistic, and clients receive a range of services catering to the needs of physical or emotional health through to the spiritual paradigm. Some clients may speak predominantly about their Islamic practice and are looking for a Shaykh. 'Islamic counselling' comes to the fore regarding issues such as magic and jinn possession. Referrals can then be made or received from sympathetic Muslim social workers or psychiatrists.

The response of the Muslim community to this perspective reflects the varying levels of understanding within the community of tibb with clients coming from all over the country to access this whilst other people find it difficult to understand the relationship between nutrition or herbalism and psychological and emotional counselling.

There is a complex diagnostic framework, which is a significant part of the learning that takes place in the diploma. This could not be simply modelled for the purpose of the scoping exercise.

Whilst in training students receive 12 sessions of supervision followed by a year probation during which case notes are submitted. The work of Dr Khan has influenced both the work of Dr Abdur Rasjid Skinner and Dr Rabia Malik whose work will be documented below.

Stephen Maynard & Associates

The therapeutic model used as a basis for training by Stephen Maynard & Associates is derived from the teachings of the science of the self with recent developmental work carried out by Shaykh F Haeri, Aliya Haeri, Sabnum Dharamsi and Stephen Maynard. Stephen Maynard & Associates⁹ maintain a small counselling caseload. The main service provided is in relation to Muslim mental health is Islamic counselling training that is nvq based and modular, running from Islamic counselling skills at level 2 that can be used in a variety of professions, to a level 4 professional qualification. The modular development responds to the need to build capacity in the community and concern to provide

⁹ Stephen Maynard & Associates is a training and consultancy partnership working in health education and social care, its partners are counsellors it is the only accredited assessment centre for Islamic counselling in the UK.

in depth Islamic therapeutic training rather than relying on Islamic cultural identification as the main stay of developing practice with Muslim clients.

The Counselling and Psychotherapy Central Award Body accredit the programme of courses provided by Stephen Maynard & Associates, and as such from 2008 all Islamic Counsellors with a level 4 qualification through this route will be registered on the National Register of Counsellors. The process of training mirrors that of all other NVQ based counselling training programmes covering NVQ levels 2 to 4. NVQ levels 2 and 3 in addition to providing a skills and theoretical basis for the level 4 are transferable to a variety of contexts enabling the use of Islamic Counselling skills in other non therapeutic professional settings. The level 4 course is a two-year diploma with additional requirements of 100 placement hours in a supervised counselling service, supervision and personal counselling comparable with all other experientially based counselling training programmes. The level 4 diploma programme is benchmarked at the same point as other models initial professional qualifications. The emphasis on vocational training was explained as part being due to the need for the development of competent counselling in the Islamic model. Feedback from qualified counsellors in the field has indicated however the need for level 5 programme due to the number of clients who present to services with serious mental health problems as well as a programme of Islamic counselling supervision. Level 4 qualified Islamic counsellors are currently providing a variety of therapeutic services through different agencies including telephone counselling services through the Muslim Women's Helpline, Prison Chaplaincy, counselling services through a women's refuge and Cruise. GP based counselling services and The Parkfield PCT Arabic Counselling Service. Further, one qualified Islamic counsellor is currently setting up initial courses based at the Markfield Institute. Students trained at lower levels (either through accredited courses or bespoke training) provide services through The Muslim Youth Helpline, Birmingham Muslim Women and Families Helpline and similar projects based in Cardiff and Glasgow. Despite the above Stephen Maynard & Associates are aware of the challenge for the mental health field in responding to an alternative model of counselling that is specifically faith based this and similar issues within Learning Skills Councils have created bottle necks in terms of the development of trained Islamic Counsellors.

Stephen Maynard & Associates see a distinction between cultural and spiritual Islam. Within this distinction what works with cultural Islam is having an understanding of how Muslim communities operate and have appropriate cultural competencies, essential for all those working with Muslims in mental health. Beyond this however, there is a greater challenge to the mental health field, which is understanding the fundamental social precepts on which we base our understanding of health and self. The training provides an Islamic therapeutic counselling framework; process and skills set which is based in the Islamic science of the self, applicable within the context of modern living. Enabling a

process of re-framing Muslim life in modernity, interfacing with mainstream counselling models whilst not replicating them or their value systems.

Islamic counselling is seen as a process of helping people to live with more contentment. The training is rooted in the revealed teachings of the Quran and the practice of the prophet and the teachings of the science of the self. Islamic counselling is based on a developmental model of health and well being as opposed to a model of illness. It is seen as a method of enabling the client to develop balance working in a way that acknowledges that human beings have a spiritual dimension that is paramount and from this perspective knowing that whatever the presenting issue is there is a root issue and that its essence has a spiritual significance. Rather than an imposition of spiritual beliefs, as a faith based model it is effective with clients with an understanding rather than a denial of their spiritual dimension.

One of the core beliefs of the model is the Quranic assertion that; "in the remembrance of God do hearts find contentment". Difficulties in life generally relate to investments in the impermanent (this underpins classical loss reactions grief, bereavement etc). The Model draws on Quran and hadith and the knowledge developed within the Muslim traditions of the science of the regarding the nature of the human consciousness and its subtleties spiritually, psychologically, emotionally, and physically. These teachings are seen as of significance across a variety of faith based perspectives Stephen Maynard & Associates have found this confirmed in practice with both Muslim and non Muslim clients. Partly the models effectiveness is demonstrated through the effective trained counsellors ability. An example of this is where a counsellor is able to transmit in a sense of holding or a spaciousness that enables the client to see that the universe is a spacious place, that there are answers for them allowing the client to come to a resolution that is beyond the immediate distress, discomfort, or 'dis-ease'.

The above process demonstrates Islamic counselling does not necessarily entail the direct use of Quranic verses or the quoting of shariah but is based on shared meaning derived from the essential teaching in Islam (that are mirrored in other monotheist faiths) applied through the Islamic model of the self to enable the client to plot their development or movement from their experience of distress or 'dis-ease'. The model facilitates a significant degree of working through reflective processes based on Islamic concepts of intention (niyat), presence (self awareness clarity of intention and focus) and understanding of the inner senses of attribution of meaning and conception or imagination. Muslims recognise many of these essential truths as inherent in their own thinking and framing of themselves and their world. This enables the development of a shared language and meanings that are not culturally specific mirroring the cultural diversity of the Muslim community though their knowledge and experience of the teachings of the Islam. Muslims want counselling that is Islamic and their experience of it once they have it (though they might not know what it is that they expect) is almost

invariably positive. Islamic counselling is a specific theoretical framework yet there are clear affinities to other models enabling the integration of specific techniques into the therapeutic practice where appropriate in the pursuit of best practice. There is an understanding of the nature of humanity, who we are and how we relate and operate that informs the techniques used.

Stephen Maynard & Associates have found that the Islamic counselling model is applicable to people of faith as well as others, but it will have particular resonance with people who are Muslim and or people who have consideration of the dynamics of their relationship with God. It provides therapeutic possibilities that are not available in many other disciplines because of its ability to work with integrated concepts of the self that include the spiritual as well as the emotional and the psychological. Its applicability is related to the root humanity and spirituality within all people, understanding that within each of us there is an aspect that reflects total perfection.

Muslims in the community perceive the training and the related counselling model well, one implication of the provision of training is the development of a greater awareness in the Muslim community of the issues of mental health and mental well-being.

The theoretical model used by Stephen Maynard & Associates is based on a number of key teachings and themes within Islam. Central to the development of the Islamic counselling model is the Islamic understanding of the Unity of God and the duality of all creation including within the human consciousness, the duality of soul and self (and then again the heart and mind). The I is a combination of both ruh and the nafs (the soul and self). Here the process of living is seen as an adaptive process of development, that is, a process of the development of the conscious (knowing and wilful) awareness of the self and of its relationship with the divine. Central to this is the axiom within Islam of the development of a person to their true potential is an aspect of one of the divine attributes of God.

The interaction between the soul and the self creates life both in terms of living in balance and harmony and in terms of imbalance or distress; the resolution of that 'moment to moment' is dynamic. An aspect of the training of an Islamic counsellor is about their integration of this reality as a lived reality in themselves, enabling the counsellor to 'transmit' a *sense* of the divine perfections of the soul to the client so that they may be aware of these perfections in their own soul and its ability to encompass the situational disharmony of the self of the client and facilitate balance within themselves.

One of the benefits of this is that the counsellor him or herself is aware of and humbled by the perfection of the soul of the client, whilst recognising human beings as prone to imbalance. The process of shift from imbalance to balance is a therapeutic one or in the wider context of Islamic counselling is an aspect of development or growth through learning.

In this context the client and counsellor are seen as gifts to one another. The true process of change taking place not due to the counsellor's actions but through them as the counsellor is part of a wider therapeutic relationship in which change originates from the divine through counsellor and client. Here the role of the counsellor in the therapeutic process is to facilitate the client to be able to enable his or her own change.

To facilitate this process requires working with a model of the Self. There are variants of this model dependent on the interpretations of the Islamic sources; the model used within the training programmes of Stephen Maynard & Associates essentially recognises that the self or 'conditioned consciousness' is complex partly due to its developmental path from lower self to higher self and partly because of its relationship with the soul (pure consciousness). If consciousness can be simply defined as awareness and will then the pure consciousness of the soul reflects its insight upon the conditioned consciousness or self. That is seen as an interaction between limitlessness and limitation. Each self has basic drives of attraction and repulsion, developing into positive and negative qualities of the self over time. For example self-indulgence or indifference and being measured are potential qualities of the self. The qualities are developed through the combined action of the heart (the seat of the soul and hence wisdom) and the mind where the outer senses (sight hearing etc) interact with the "inner senses". The interactions of these inner and outer senses produce the reality of the individual through the quality of their thinking. In addition to above there is an aspect of the self that monitors the actions of the self, enabling self-reflection. The model is developmental in that the development of the qualities related to the drives and the evolution of the thinking process, the self develops through stages including the commanding self (Al-nafs al-ammara), the reproachful self (al -nafs al-lawwama) the inspired self (al-nafs al-mulhama) and the certain self (al-nafs al-mutma'ina). Though the model of the self is holistic within the work of Stephen Maynard & Associates in its training provision focuses on talk therapy, this being a focus of provision rather than a limitation of the therapeutic model. Islamic counsellors have integrated other processes such as body therapy into their practice.

The practical application of the model is based on the ability of the counsellor to work with the language of the client. This means that the counsellor internally maps the issues and process of the client whilst engaging with the client at a therapeutic level in their presentation of their experience as many Muslims are not aware of the Islamic science of the self. Alternatively they may use the science to build a language with the client that enables them to see their experience of world in a cohesive spiritual and psychological frame, this allowing them to use their understanding of Islam in a practical way. In both cases it requires the counsellor to develop the ability to hear behind the negative or positive qualities presented by the client the divine attributes that enable them.

Stephen Maynard & Associates term this “proactive listening”, an essential aspect of the counsellors work.

Applications of the Stephen Maynard & Associates model in practice are the Muslim Women’s Helpline and the Arabic Counselling Service.

The Muslim Women’s Helpline

The Helpline was possibly the first Islamic counselling service in the UK, providing a telephone based advice and counselling service. The helpline offers a limited hours advice support and counselling service for the UK from its London base. The Helpline had always trained its volunteers in the Islamic counselling model to a level where support advice and befriending and referral services where could be provided. In recognition of client demand due to the levels of psychological distress the helpline trained a selection of its volunteers to the level of NVQ 4 in Islamic counselling enabling it to provide a more in-depth service.

Though the service provided includes Islamic counselling the service still describes itself as a telephone support and advice agency, this is in part due to an inability to match counselling resources to the level of need. In this context clients requiring therapeutic work are referred internally to its two Islamic counsellors while the other volunteers support the remaining clients. Clients find the service very beneficial. However there are related problems. One of these is the level of demand from women who contact the helpline regarding their experience of a problem within the family. This often requires an appropriate intervention with another member of the family (for example a husband or son). Further the lack of appropriate services to refer on to nationally for Muslim women means that a significant number of clients remaining in contact with the helpline for periods of a year or more rather than be referred to locally based agencies.

The Arabic Counselling Service Parkside Clinic

This service was developed as a response to the large Arabic and Muslim Communities in the North Kensington area the service is offered as a family orientated service to local Arab and Muslim communities and operates as part of CAMHS. The service is a multi disciplinary children and adolescent mental health team working at tiers 2 and 3 offered ostensibly to ‘Arabic’ communities by virtue of culture, language, or religion. The service is managed by a full time Islamic counsellor within a team comprising of:

- A half time family therapist,
- A half time social worker,
- One day per week an art therapist,
- One day per week a second social worker
- Half a day per week a children and adolescent psychotherapist,
- Half a day per week a consultant adult psychotherapist,

Two and one half days per week (in total) additional counsellors (qualified in humanistic models and trained to level NVQ 3 in Islamic Counselling.
Administrative support

The service provides a variety of interventions around a core offering of Islamic counselling, including Family therapy, Child and Art Therapy. In addition through working in partnership with The Muslim Cultural heritage Centre the service provides a half-day walk in service in the community and a parental support group. A significant number of clients who had been reluctant to engage with services prior to the provision of Islamic counselling through the Arabic Counselling Service have self-referred for Islamic counselling. In addition there have been a number of situation where in this approach has proven effective where other treatment methods had not.

The demand for the service is high with a current six month waiting list for Islamic counselling including referrals from outside of the PCT's catchment area.

The theoretical model used by the Islamic counsellor though essentially the model used by Stephen Maynard & Associates has had to adapt. Having been trained to level 4, a competency level sufficient to work with common mental health problems the Islamic Counsellor/Primary Mental Health Worker has found herself on a number of occasions whilst working in partnership with other members of the team, working with clients experiencing severe mental health problems. The resultant skills gap has been filled through her developing knowledge of other models through her support and supervision. Further training in Islamic counselling and or Islamic counselling supervision may in addition be of benefit to the development of the service.

Islamic therapy

The above term is used to describe models of Islamic intervention that relate to variations on the Islamic model of the self rooted within tibt or nafsiyat but have been developed by psychologists or psychotherapists through the integration of Islamic models of practice and existing psychotherapeutic models of practice. The models involved are Cognitive psychotherapy, Jungian psychotherapy and Systemic family psychotherapy.

Dr Rasjid Skinner Linfield Mount Hospital Bradford

The service developed by Dr Skinner has been in the context of his work as a clinical psychologist providing services for the elderly through GPs clinical referrals at the Linfield Mount Hospital in Bradford. Here he has also developed a case load (for which he does not charge) in the community working with adults under the age of 60 across a variety of diagnoses in the Bradford.

Dr Skinner provides a culturally meaningful explanation for clients' mental distress as well as advice on how to deal with it, rarely having to do intensive medium term therapy. The service generally is short term and not intensive though there are exceptions for example working with trauma cases.

Here Islamic psychotherapy in its broad sense is seen as a mixture of the Islamic model of the self regarding vocabulary that the client will understand and fiqh (Islamic law within one of the identified schools) based advice. Allowing for concepts such as possession and other experiences to be discussed in a therapeutic context.

The process is one of reframing using techniques based in cognitive therapy working with the religious cognitive schemes or basic beliefs of the person; it is not deep psychotherapy.

The framework is based on a model of understanding the qalb or heart, nafs (psycho-emotional drives) and the body and how these interact within the person. Dr Skinner has found that in his work with non-Muslims Jungian terms effectively replace the Islamic vocabulary, he in this work maintains the same frame of understanding. Various techniques are applied as appropriate within the specific culturally and spiritual framework. The Islamic psychotherapeutic process involves perceiving how the client understands shattering experiences in relation to the things that matter to them. For Muslims that most often is their Islamic understanding of the self and the world. In his experience it has proven easier to work with Muslims than non-Muslims due to their holistic Islamic understanding of self, creation and God so simple interventions have often been very effective. Where advice is given it is in the framework of the shariah (generally clients are not looking for advice that takes them out of it).

This work can be related to a variety of issues, for example clarifying differences between adab (appropriate courtesy) and authority, or working with a client's cognitive dissonance (for example between traditional Pakistani cultural understanding of Islam and the current context of life in the UK). Much of the work was reported to entail a process of enabling the client to find the root meaning of their experience. Within this process enabling learning about Islam objectively is part of the service and takes 50% of the time.

Being a holistic intervention Islamic psychotherapy takes account of the spiritual and experiential parts of the self, the cognitive processes, the drives and the soma. Combining this with both the growth changes in the self as well as the static model of balance. Here people are seen to be in a state of imbalance stressed by a problem (consciously or unconsciously) then they return to a state of pre stress. There are similarities to the Jungian concept of integration the epicentre of these problems is the aql (intellect), the nafs or the body state of being 'coloured' by the drives of the nafs.

Within this model symptoms can be at any of these levels and their resolution involves a process by which the self expands (gains a deeper understanding). This may involve the development of an aspect of the self. Broadly this involves things to do with the qalb (the heart, the connection between the self and the soul) the process of growth may be experienced as distressing. (Jung has a similar conception, individuation) the outcome is that the self is more than balanced the self has grown.

The diagnostic process is based on identifying the epicentre of the problem whilst noting ancillary problems and acting accordingly while dealing with the core issue. For problems that are trauma, related psychotic in nature or cases of severe depression (even when the symptoms are culturally defined) Dr Skinner works within the medical model. Outside of this he has found that the normal model of mental illness is not necessarily helpful. Often disease categories are created and hence not robust, or clear, or lack a baseline, as there is generally a lack of conception of mental health in contemporary psychotherapy outside of the work of Jung or Maslow. Within the Islamic process everything has draws its meaning or significance compared against a conception human well being. From Dr Skinner's perspective in mainstream mental health work people feel ill because they are defined as such where they are in a state of distress this may in fact be a state of growth. Conditions that appear to be primarily physical Dr Skinner also refers on (often to a Hakim).

Clients tend to find his service of great value having little trust in standardised mental health services. His client group comes from a relatively small community in Bradford with established networks and hence there do not appear to be issues in relation to accessibility. The main measure of performance is patient satisfaction in the hospital setting or the informal networks. Dr Skinner confers with Dr Khan.

Dr Skinner operates in the ethical framework of a clinical psychologist as well as within the context of Islamic adab (courtesy or appropriateness).

“When ‘someone comes to you for something you receive what is for them and hence are enriched by the process it comes through me not from me... part of my duty given the means and the person also enriches me’.

Here it can be seen that the entire process relates to the state of the therapist when providing therapy the process is a receptive process. The length of service provided ranges between 1 session and two years, typically it is five sessions.

Dr Rabia Malik The Asian Arab Counselling Service The Malborough Clinic
Dr Rabia Malik is part of a specialist service The Asian Arab Counselling Service started 11 years ago in response to acknowledgment of low response from BME clients. This is one of two services provided through Parkside PCT the other the

Arabic counselling service being part of CAMHS. Dr Malik had studied Islamic tibb in her doctorate and blended this knowledge with additional 'out of hours' training, her knowledge base as a family therapist and applied it to her work when working with Muslim clients. With an increasing number of Muslims requesting a Muslim therapist talking about faith has become an explicit part of the work.

Dr Malik presents as a family therapist and a Muslim with some knowledge of Islam, not as a theologian or an Islamic counsellor. In her work she is aware of a holistic Islamic notion of the self where mind body and spirit are connected. In Dr Malik's experience when Muslims talk about their emotional distress they talk about it in relation to spiritual and physical terms as well and they relate it to Allah and that is important in accessing their sense of agency.

In terms of what she takes of a faith perspective to her work it is her relationship with Allah and the clarity of her own intention. This as well as acknowledging the role of faith in people's lives provides an opportunity to explicitly bring into the process the clients beliefs or faith by helping them to think about their lives in ways that draw on faith.

As part of a multidisciplinary team Dr Malik has access to a team of social workers psychiatrist etc so that in serious mental illness through joint work she can keep the cultural or faith based aspects at the forefront of the work. Her experience is that in the context of most generic NHS provision when Muslims see professionals Muslims do not expect them to understand spiritual or cultural aspects of their experience so Muslim clients edit it out. Muslims clients have a confidence the service through their experience of a 'Muslim' who is a 'therapist'. To Dr Malik if people know that she has engaged conceptually with Islam and psychotherapy in a way that seems thought through it gives them confidence. A concern of Dr Malik's is that in some cases clients request for a Muslim therapist may be met inappropriately through a lack of therapeutic competence. Here the faith might be an initial distinguishing feature but the therapeutic ability has to be more than that.

Dr Malik's model of work is a systemic. Here to understand a human being or a particular family unit she works from an understanding of the other relationships around them including social, cultural and religious. Aware that relationships are born out of religious and cultural assumptions she brings to this knowledge from her engagement with Islam as a system of beliefs and meaning as well as her own cultural understanding of self and mental health. This enables Dr Malik to work within the metaphors commonly used by her clients. From Dr Malik's perspective it is necessary to engage with the clients belief system with the conviction that there are solutions in all systems. Clarity in her intention and 'connected' with Allah are seen as part of a process of opening up a way that is meaningful for her and her client enabling them to arrive at a solution.

Assessment of Dr Malik's work is based on her reflection on her practice and through making it transparent to others. Diagnosis or assessment in her practice is dependent on what the client identifies 'it' as. If it has elements that overlap with a mental health frameworks then Dr Malik would bring this into the discourse and negotiate it with the client in order to access additional services and resources. Dr Malik takes an anti diagnosis stance, in her experience the disorder defines the person labels organise the thinking and develop a phenomenon.

"Solution is dependant on the definition of the problem and if the client calls the problem something different to what you call it then there is a problem."

Dr Malik receives supervision from Dr Hakim Salim and is currently carrying out his training. Her clients in general receive 10 weeks some clients will work long term over a period of several years.

Analysis and Conclusions

The ethnic diversity, distribution and scale of the Muslim community may in many respects make this community difficult to codify in relation to social policy. There has been an increasing recognition of the significance of faith in relation to areas of social policy such as social cohesion. However the 'ill health focus' of modern mental health care may lead to different ways of labelling or seeing social groups as opposed to in relation their own phenomenological or faith based perceptions.

It may be more apparent to classify communities in terms either of their ethnicity and race for example South Asian, Indian, Eastern European or Northern Nigerian; or in relation to collective experiences, which brings them into contact with services, such as refugees or unaccompanied asylum seeking children. These forms of identification have significance. However in regards to mental health the way that a person or group of people identify 'themselves' particularly when that identification structures their collective understandings of 'self' and their relationships with the world, informs an understanding both of mental health and mental illness.

The social context of the Muslim community including its history of migration, its experience of social change, and its experience of social exclusion, as well as the complexity of the community with its dynamics regarding its own current cohesion are indicative of a significant degree of mental distress or mental ill health within this population. This is despite the evidence of the literature review and the interviewees documented within this report indicating the positive effects of Islamic faith on mental health. Such evidence is indicative of a form of resilience within the community despite both its experience of social exclusion and any potentially maladaptive responses to its social context.

Despite this apparent faith based strength or resilience within the community the evidence of need is indicative of both the complexity and the severity of need for mental health services and support within Muslim Communities. This does not indicate specific 'pathology' within the Muslim community but it does indicate that the community through the combined experiences of social exclusion and rapid social change has a selection of difficulties including some of which are specific to it. The experience of Muslim communities post 9/11 have increased the perception of alienation within the community facilitating in some situations reactive responses to a heightened sensitivity to apparent threat. These responses in themselves may become stressors or prove to be maladaptive.

In this context the ability of mental health services to respond with effective provision has apparently been hampered by different conceptualisations between professional and Muslim communities of problems within the communities and possible solutions, and the resultant the mistrust of the community of mental health service provision.

The existing evidence regarding generic mental health services is indicative of the inability of mainstream services to access this client group and of the need for the development of new ways of working. Consultation with organisations, both in mainstream and targeted organisations, indicate that many Muslims do not access counselling support or other mental health services for three reasons:

- firstly the belief that there are no appropriate services for Muslims and,
- secondly the inaccessibility of service.^{10,}
- thirdly the lack of awareness of mental health as an issue or its denial.

Whilst the first two above perceptions exist mental health promotion in itself in Muslim communities is likely to have little impact. What is necessary is the development of faith and culturally sensitive ways of working with Muslims that enable them to explore their experience of reality without critique of their core beliefs. Such faith-based work due to the integrity of the core beliefs has been found to not only combat mental illness but facilitate mental and spiritual well being.

Further mapping of alternative provision within the Muslim community indicated significant gaps in service as well as basic infrastructural problems such as poor funding in the existing services; services, which may be able to provide new models or examples of best practice. Generally health services need to engage in a process of developing an understanding of Muslim mental health that is

¹⁰, DoH Inside Outside, Muslim Youth Help line, Muslim Women's Help line, Parkside PCT Arabic Counselling Service, An Nisa Muslim Women's Organisation

shared within Muslim communities. Through this shared understanding an effective language that is robust enough for use both in discourse with the community and in professional contexts must be developed in order for mental health services to work equitably with the community rather than inevitably reframing Islamic understandings of mental health within the medical model framework. This requires the recognition within statutory services of the value of the Islamic schema and ability therefore to adopt new ways of working.

Some of the nature and meaning of mental health mental distress and mental illness in the Muslim community have been indicated within this report however further peer led qualitative, as well as quantitative work is required. Such work will need to focus on within the community in relations to specifics such as adult female mental health or ill health, adult male mental health or ill health mental health in emergent communities and young people and mental health.

With regards to the theoretical models, it is evident that there are a number of perspectives in relation to how to work with Muslims regarding mental ill health or distress. It is evident that within the dialogue between models there is further questioning of the nature of the problem in relation to mental health in Muslim communities and an emerging critique of the medical model.

The variety of perspectives in part reflect different emphases in relation to faith and culture regarding the Muslim community as well as different knowledge bases within Islam and within modern mental health. Simply taking into consideration the differential experiences of faith, culture and hence Muslim identity within the British Muslim community there is a clear case for arguing that a one size fits all perspective on Muslim mental health is not likely to be successful: there is a need for a variety of entry points to service with different but complementary models. In relation to the provision of services to young people such a variety of entry points could be mapped in partnership between statutory and community based services across service provision.

Initiatives such as Community Development Workers programme, which led to the development of Sharing Voices, indicate that agencies can develop participant led responses to mental health needs. Such initiatives when developed with sufficient support enable ownership by participants and go some way towards re-framing the discourse on mental health within the community. The strength of the participant led initiative model is its engagement with Muslims in relation to their understanding of mental health and what is pertinent to them. Though Sharing Voices was not a Muslim initiative there is important learning in the therapeutic use of dihr and the development of multi cultural inclusive Muslim women's peer support.

Organisations such as the Muslim Youth Helpline, Nafas, the Muslim Women's Helpline and Sakinah provide useful project models of practice in relation to issues of access whilst enabling either entry level or issue specific complex work.

The accessibility of these services as organisations that provide a space for the clients' exploration of their cultural or religious identity if they wish supported by peers is valuable. The Muslim Youth Helpline is currently engaged in an analysis of its service and from this it is anticipated that there will be lessons in relation to good practice. The interviews with Nafas and the Muslim Women's Helpline also indicated that valuable information regarding both client needs and ways of working could be developed from peer led research. The significance of the Sakinah project model appeared to be its response to the 'cultural' identification of Muslim and specifically Asian Muslims. This is again a strength in its recognition of and responding to a perceived need in the community. Though in the context of Sharing Voices Muslims came together despite cultural differences to explore the specific therapeutic strengths of working from an Islamic perspective in relation to mental health this can not be expected in all communities. Individuals and communities evolve and cultural similarity may at certain times present as a more significant factor than faith or core beliefs.

Within the work of Islamic counselling and Islamic psychotherapy there is a set of Islamic models and Islamic psychotherapeutic hybrids that provide valuable insights into the processes of working therapeutically with Muslims in accordance with their core beliefs. This is a developing field, the expertise in modelling training and practice in the UK residing in a limited number of individuals. It is not possible to effectively complete a detailed comparative analysis of these models and their related applications within a scoping paper. It is likely that such an exercise would require longitudinal comparative analysis of the actual impact of these models. It must also be noted that as not all of these models span both training and practice there are for some issues in relation to replication.

From the evidence above there is a clear need for both a strategic approach to the replication of effective ways of working with Muslim communities as well as a need for further study of the available models of practice in the context of an evidence base that accurately describes the nature of mental health or ill health within an Islamic context.

Though further research is required there is an evidence base of innovative practice within Islamic counselling and Islamic psychotherapy, which compliments existing services in working effectively with Muslim communities. In addition by providing new insights through faith Islamic counselling and psychotherapy models broaden the discourse regarding mental health and well being.

Recommendations

Following the findings of this report a number of recommendations have been made in relation to key themes within the work.

Regarding the complex needs that exist across the community and the lack of data relating to them there is no real baseline within the changing demography of Muslim mental health.

Recommendations:

- Further peer led research is necessary regarding mental health in Muslim communities. This should include both quantitative and qualitative studies targeting gender, age and ethnic community specific target groups.
- Further consultation with Muslim professionals working in related fields e.g. domestic violence, sexual health, disabilities, substance misuse, social care, youth work, education is required to clarify issues of mental well being in Muslim communities. The development of networks across disciplines to enable greater understanding of the issues relation to Muslim mental health is recommended.

There is a need to develop the evidence base of effective interventions with Muslim communities

Recommendations:

- The evaluation of the value added brought to existing mainstream service provision by specialist services and clarification of what is gained through the various levels of service provision. This will require the secure financial support of voluntary, and statutory sector initiatives providing specialist services to the Muslim community enabling the stability of services and the development of an evidence base.
- The work of Stephen Maynard & Associates, the Mohsin Institute, Dr Malik and Dr Skinner should be supported in relation to the development of Islamic counselling and psychotherapy. A network should be resourced and facilitated enabling the development of good practice in counselling and psychotherapeutic work within Muslim communities.

There is a strategic and immediate need to extend the availability of therapeutic interventions within Muslim communities this may at present best be done through the extension of Islamic counselling services.

Recommendations:

- Both the models of the Mohsin Institute and Stephen Maynard & Associates should be supported in relation to their further development. On the basis of further development and evaluation a national programme for the deployment of training should be embarked upon targeting all Muslim populations in excess of 10,000.

- A fast track programme of Islamic counselling training in a number of locations should be embarked on to provide an initial skilled workforce for the voluntary and statutory sectors in the locations with the greatest concentration of Muslims. The work of SMA in providing an accredited progression route to a professional qualification in Islamic counselling should be engaged in relation to the initial fast track programme*.
- Islamic counselling training should be provided to key Imams and voluntary agencies who are currently engaging with individuals in the community exhibiting mental health problems, as well as a post qualification training being developed for therapists within the statutory services working within Muslim communities.

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- Stephen Maynard & Associates are one of the key providers within this field. However it should be noted that they were also commissioned to carry out this research on the basis that expertise within the field is limited. This may lead to bias within the recommendations; however care and attention to ensure good research practice has been taken to prevent this.

Appendix 1

A proposed fast track route for development of Islamic counselling

Muslims represent 2.9% of the population of England and Wales, 35.4% of the BME community in England and Wales. In this context the absence of appropriate mental health provision has far reaching implications. The strong correlation between deprivation and the social origin of many mental health conditions within the community also are indicative of the need to develop services in mental health and or related fields, which then may have a preventative effect in relation to mental illness. The lack of culturally sensitive provision with regards to mental health problems or other less traumatic life problems is part of the environment in which both the case for a strategic approach to the development of Islamic counselling services and the case for a fast route for the development of such services is made. The distribution of Muslims in the UK is most concentrated in the key cities represented in table 1.

Table 1 Muslim populations in the above identified cities as recorded in the 2001 census.

Location	Muslim Population	Muslims as a percentage of the population
London	607,083	8.4%
Birmingham	140,033	14.3%
Greater Manchester	125,219	5%
Bradford	75,188	16%
Kirklees	39,314	10.1%

Taking into account all other urban locations with a Muslims population in excess of 10,000 as identified in England and Wales in the 2001 census we find that this presents an additional 9 locations as follows:

Table 2 Towns and cities with Muslim populations in excess of 10,000

Location	Muslim Population	Muslims as a percentage of the population
Leicester	30,885	11%
Luton	26,964	14.6%
Sheffield	23,819	4.6%
Leeds	21,394	2.9%
Slough	15,896	13.3%
Walsall	13,605	5.3%
Sandwell	13,053	4.6%
Coventry	11,687	3.8%
Cardiff	11,261	3.6%

The locations identified in tables one and two account for approximately 75% of the Muslim Population of England and Wales.

It is proposed that an initial programme of rapid development of an initial framework of counselling services be developed in London, Birmingham and Greater Manchester three of the five locations identified in table one. Further it is proposed that the development of Islamic counselling services be undertaken through partnerships of both statutory services including mental health services and voluntary sector services with the aim of increasing access. Partners would agree the specific boundaries of services on the basis of Muslim community distribution and service partnership catchment areas.

The fields of health, children's services and adult social care all carry responsibilities in relation to mental health and as such are the most significant fields where appropriate counselling provision can serve the Muslim community. The Muslim community voluntary sector including mosques, working in partnership with the statutory services would be able to develop a network of access points to Islamic counselling.

It is proposed that Stephen Maynard & Associates working with locality based strategic partnerships provide training and consultancy to enable the deployment of initial Islamic counselling services in the identified areas over a 3 to 5 year period. Further it is proposed that this programme in addition to the other programmes recommended be evaluated to further develop the evidence base in relation to the model.

The focus of this initial development work would be the provision of counselling services which would be tailor made to the specific requirements of the location Stephen Maynard & Associates working with the membership of the partnerships will facilitate the development of staff to provide Islamic counselling services at a variety of levels through accredited training programmes. In developing the skills base across professional partnerships it is anticipated that the most urgently required staff in the areas of highest Muslim densities would be prioritised for training this may require more than one programme per conurbation and would be based on the collation of existing data or if necessary local needs analysis.

Concurrent with the need for the rapid development of services is the need for the development of the evidence base. Though there is evidence of the effectiveness of Islamic counselling documented in a number of papers there still exists the need for further qualitative research analysing the application of Islamic counselling across a variety of settings. It is envisaged that research should be commissioned to clearly evaluate the initial fast track programme and its outcomes.

The partnerships in relation to the development of Islamic counselling

The process of rapid development of Islamic counselling services would focus on the needs of a variety of organisations as identified on the ground considering both local demographics and competing priorities and national policy or legislation in relation to mental health as identified in health, social care and education. By working in partnership and considering local needs it is anticipated that there may be the ability to:

- A) build resources quickly in innovative and responsive ways;
- B) share resources enabling the development of services to have a lower cost imprint;
- c) plan the development of both local services in a way that responds to cross cutting themes enabling joined up planning.

To facilitate this process would require the development of partnerships or virtual partnerships with a membership able to act strategically across agencies or with clear delegated authority to participating officers. It is proposed that these partnerships be led by Primary Care Trusts. Additional funding will be required for the fast track programme, taking into account the development of new services, pooling of budgets may to a degree offset this requirement. In order for these partnerships to have the maximum impact they will need to operate a number of levels. The membership will need to include commissioners with a strategic understanding of the related priorities and cross cutting themes. In addition they will need access to operational service providers with the ability to provide and interpret the experience of Muslims within Specific communities.

Due to the particular implications of the dispersions of Muslim communities the areas covered in the three partnerships will be quite different each with its own specific logistical implications. The initial fast track programme is not designed to provide pan London Birmingham or Manchester services but the development of specific services within these cities in the areas of greatest and or most distinct need. The final decision regarding which partnerships will participate in the fast track programme will be made partly in relation to the different challenges of working with different types of Muslim community, and the different approaches utilised by the partnerships in relation to these challenges so as to provide a robust data base prior to the development of a wider programme.

It is likely that some degree of interrogation of data collected across agencies or interagency mapping may be necessary as part of a process of identifying the priorities for action, in addition to protocol negotiation for the development of joint resources. Mechanisms for community consultation to assess the impact of the development of services on local communities will also be necessary, where appropriate Mental Health Community Development Workers exist in the initial partnership areas these workers may play a beneficial role both strategically and

operationally. It is anticipated that this proposed process of planning for the development of new services in relation to predominantly BME communities will provide new and innovative solutions to recognised problems in accessing and resourcing communities in significant need.

Potential milestones in Islamic counselling service development

There are a number of potential routes towards the rapid development of services. It is proposed that service development be shared between agencies providing related services to similar client groups, services such as the PCT, The Mental Health Trust, The Voluntary Sector services for women and families, mosques, Children's Services and Youth Services within a specific location.

It is also possible to base the development of services on either the training of existing staff; for example the training of a selection of social workers to level three or the training of existing psychotherapists and counsellors to level 5, the recruitment and development of new staff or through a combination of both procedures.

Considering the above the following are a selection of potential routes towards the development of services.

1. Developing an initial community based Islamic counselling service with links to existing service provision for work with severe mental health problems

The objectives would be to develop a team of level 3/4 proficient service providers with Islamic counselling skills or Islamic counsellors who would be able to work within the community preferably from a community organisation or organisations and with a variety of mother tongue languages matched to those of use in the Muslim communities to enable access to mental health services for Muslims. Such a service would be functional as an assessment and referral service in eighteen months as a counselling services (but reliant on external supervision) in three years and functional independently in five years.

Milestone	Year 1	Year 2	Year 3	Year 4	Year 5
Train a team of health trainers to level 3 in Islamic counselling					
Purchase a limited service from existing Islamic counsellors					
Develop Islamic counsellors to level 4					
Develop Islamic counselling supervisors to complete the development of a self-sufficient service					

2. Developing a team of specialist staff in statutory services through workforce development and outreach work

This could occur where a specific agency such as a PCT has a pool of existing staff that through training can develop an additional service to cater in a culturally appropriate manner for the needs of a Muslim community.

Milestone	Year 1	Year 2
Develop existing clinical staff as level 5 Islamic counsellors through continuous professional development		
Provide an Islamic counselling service along side existing services enabling client choice		
Develop Islamic counselling supervisors to complete the development of a self-sufficient service		

3. Cross agency Islamic counselling service development within a specific location

Where a number of agencies come together to develop shared services to provide a localised response to complex needs and issues within a specific community. To illustrate this the case chosen is led by the education authority through community schools. The objective would be to develop a comprehensive service targeted to the needs of a specific Muslim community.

Milestone	Year 1	Year 2	Year 3	Year 4	Year 5
Liaise closely across the services and with key members of the community to identify specifically the level of intervention required and the for specific identified issues					
Train a combination of staff from across a variety of agencies statutory and voluntary– this may include family aids and youth workers to level 2 or 3					
Train a second tier of staff possibly a combination of youth workers, social workers and CAHMs staff to level 4					
Develop Islamic counselling specialists to level 5, to work in depth with the presenting complex need					
Develop Islamic counselling supervisors to complete the development of a self-sufficient service					

4. Develop services from within the existing community networks, Forming a variety of Islamic counselling services in the community with the aim to maximise ease of access to service. Here the objectives are to develop a series of access routes to counselling services within existing voluntary and community networks and increase awareness of psychological health and mental health in the Muslim community.

Milestone	Year 1	Year 2	Year 3	Year 4	Year 5
Working closely with the community and the voluntary and community sector train a wide variety of people to level 2 In Islamic counselling facilitating a discourse within the community regarding mental health, and enabling members of the community to see the way in which their faith and life choices and mental health services can relate.					
Train a smaller selection of members of the community to level 3 who will be able to work through the existing community and voluntary sector structures contracted to the PCT to provide access routes to existing mental health services					
Develop Islamic counsellors to level 4 to work within the existing voluntary sector contracted to the PCT to provide GP based Islamic counselling through GP based commissioning					
Develop Islamic counselling supervisors in either the voluntary sector or in the PCT.					

Participants in the scoping process

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A selection of Imams of Mosques in London and Birmingham and Muslim Chaplains who prefer not to be credited

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