Better Community Business Network

# HIDDEN SURVIVORS

## UNCOVERING THE MENTAL HEALTH STRUGGLES OF YOUNG BRITISH MUSLIMS

*Partners:*

UEL University of East London

Inspirited Minds

THE MUSLIM NETWORK COLLABORATION

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## UNCOVERING THE MENTAL HEALTH STRUGGLES OF YOUNG BRITISH MUSLIMS

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# MENTAL HEALTH AND WELLBEING OF YOUNG MUSLIMS IN THE UK

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# About BCBN

The Better Community Business Network (BCBN) is a Muslim-led grant-giving organisation set up by a group of business people and professionals who have come together to support local community projects that make a real difference to the communities they serve.

BCBN seeks to identify and address socially challenging causes, acting as a conduit between businesses, grant-makers, charitable trusts and foundations to serve communities and create a positive change. BCBN avoids duplication and carefully partners with credible organisations in creating and delivering bespoke, specialist and focussed charitable programmes to increase service delivery to hard-to-reach communities. We commission research for a more targeted and effective, evidence-based approach to the projects we support long-term.

Since its inception, BCBN has raised over £1.3million in funds for community causes and has attracted support from respected figures such as HRH The Prince of Wales; Former Deputy Prime Minister, Rt Hon Nick Clegg; Former Justice Secretary, Rt Hon Chris Grayling; and Mayor of London, Rt Hon. Sadiq Khan amongst others.

For more information, visit bcbn.org.uk

B C Better Community
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# Foreword

I would first like to thank the Better Community Business Network for putting together this important report and to everyone who has supported and contributed to its research and development.

Even before the pandemic, there was a crisis facing our young people's mental health and it is undeniable that they have also suffered immensely throughout. Deprived of so many of the opportunities and experiences that guide each young person into adulthood, it is vital that we put their mental health and wellbeing at the heart of policy making and our coronavirus recovery plan.

Providing a vital insight into the experiences of young Muslims who have access to mental health services, this report reminds us that anyone - regardless of background - can suffer with their mental health and there is no, one size fits all, approach to support. Nevertheless, as this report emphasises, as a society, we have to understand the role played by cultural context and intersecting identities - including religion - when understanding and working to support those struggling.

As a Muslim woman, it is gratifying to read this report and learn that 59% of respondents say faith plays a positive role in supporting their mental health and wellbeing. However, as highlighted in the report, it is important to recognise that faith can also act as a risk factor both from self-induced feelings of guilt and shame for seeking help and external factors such as Islamophobia and institutional racism potentially aggravating the mental health challenges faced by young Muslims.

As a doctor, I agree with the 61% of respondents who said that it is important that mental health services display cultural and faith sensitivity. Indeed, faith is a protected characteristic and sensitivity is vital across the health and social care sector to ensure that young people feel heard and understood when seeking help and support. As stated in the report "diversity is about more than meeting equality targets, it is about placing the needs of service users at the heart of service commissioning, development and delivery".

The 17 recommendations made in this report underline the key steps we need to take to ensure that young Muslims struggling with their mental health are not hidden survivors, but supported service users.

Moving forward, there needs to be a more sophisticated and honest discourse around the role and impact of faith when seeking to support young Muslims, not just in the health and social care sector, but also within our universities and -most importantly - our Muslim communities. Crucially, as part of reforms to the Mental Health Act and the development of a Patient and Carers Race Equality Standard, the Government needs to take due consideration of religion to ensure that services are equipped to deliver an outstanding quality of culturally appropriate care to Britain's diverse population.

Rosena C. Allin-Khan

Rt Hon. Dr Rosena Allin-Khan MP

# Foreword

I was affected deeply by reading this report. Among my reactions was shock at the mental health needs faced by young British Muslims and the barriers to them accessing support; deep sadness at the impact of Covid-19 on these our fellow citizens, and determination that we must do something about it.

At the same time I felt that this report presents us with an opportunity to shape our response.

The report invites us to learn multiple lessons. The notion that faith and spirituality is unimportant in our society is simply not borne out by the experiences in this report. The striving of young Muslims to integrate their lives, their health and their faith despite barriers and obstacles shines through, and we must make common cause for the mental health of our young people. Our population cannot be healthy without everyone being mentally healthy. That means our population cannot be mentally healthy without young people of faith being enabled to be authentically and truly themselves. Equally importantly, good mental health for people of all faiths is a theological and pastoral task every faith community must rise to.

The impact of SARS-CoV-2 has worsened already existing unmet need and inequalities. Covid-19 placed an unequal burden on our communities, as the 2020 Public Health England Report "Disparities in the risk and outcomes of COVID-19" made clear. A huge collective trauma has been experienced by our population, and unequally so. We need to learn to respond to that. If we simply move on without learning this, we risk grief and pain turning – predictably and understandably - to grievance, distress and disaffection. If this does happen, our lack of response to the mental health needs of our young people will be in no small part a cause of this.

The impact of Covid-19 will be felt in ways multiple and far-reaching for some years to come across our populations. It has not been a pandemic, but a Syndemic: multiple waves of impact, interacting between one another and in the case of Covid-19 having impacts ranging from physical health to psychological, spiritual and economic distress[1].

But there is cause for hope. The report makes clear we can act. The report also makes clear faith is still relevant, and the work of faith communities through the pandemic was illustrated strongly and dynamically by the many faith communities present on the Government's Faith Task Force, a Task Force I was privileged to serve.

But most importantly, just as much as there has been a syndemic and systemic effect of the multiple impacts of Covid-19, we must build systemic and converging responses. No one action is enough, no single agency sufficient. All of us, from parents to faith communities to schools, employers and public services, can do something to improve the mental health of young British Muslims. This report is timely, it is a call to action. Let it shape our response, deepen our recovery, and be an instrument on which to bring about the flourishing of our young Muslim citizens.

Professor Jim McManus
Vice-President, Association of Directors of Public Health
Director of Public Health for Hertfordshire

[1] Merrill, S. (2009) Introducing Syndemics: A Critical Systems Approach to Public and Community Health. Wiley

# Foreword

In BCBN's short history, we have formed many successful collaborations and helped develop pioneering programmes, ranging from refugee support services, Muslim fostering to ex-offender housing programmes. Our approach has been one of careful consideration and due-diligence, identifying the right delivery partners to build upon expertise and experience for specialist and targeted support. We do this with the aim of providing effective, sustainable solutions to the challenging situations we face as a British community. This exchange in learning and skills, capacity building, facilitation and collaboration is what makes our approach both unique and inclusive.

We have had the honour of working with some of the most leading civil service and charitable organisations in co-designing and producing ground-breaking and forward facing projects, and commissioning research for a more targeted and effective, evidence-based approach to the projects we support long-term.

Our most recent efforts, over the past few years, has been in identifying, engaging and forming consultations with mental health and well-being support services, and those with lived experiences from the Muslim and wider community to inform our understanding and focus.

The report identifies and highlights the crucial and effective work that is being done across the community. It is encouraging to see the change in perception and access to mental health support services, particularly where efforts are being placed in creating faith competent services, increasing engagement and representation of the Muslim community.

We hope the report and its uncovering of hidden survivors will provide the prompt needed for organisations and support services to consider how to embed improving young Muslims' mental health in their future work programmes. We encourage service providers to record and capture faith data to increase awareness and faith literacy, to improve access for service users and their experience. We seek to facilitate faith and cultural competency training delivered across the sector and beyond to build understanding and exchange, encouraging faith-sensitive approaches to Muslim mental health and well-being. To enhance community efforts through recognition, sign posting and integrating faith-based and community services into mainstream and statutory services, to increase access and engagement.

I look forward to the next phase of this journey and invite supporters and service providers to identify and action practical steps in building upon the learning and recommendations highlighted in this report and improve service delivery for a fair and adequate pathway to support and recovery. For those hidden survivors and their struggles with mental health to gain more confidence and assurance in our public health and community services that seek to improve and help the lives of vulnerable people.

Sabah Gilani

Sabah Gilani OBE,
Chief Executive, Better Community Business Network

# Acknowledgements

I would like to begin by expressing my deep appreciation to the Muslim mental health steering group (convened by BCBN at our offices in Battersea Park) - Abdullah Maynard and Shabnam Dharamis (Institute of Islamic Counselling & Wellbeing), Shaykh Fahimul Anam (Muslim Family Matters), Khalida Haque (Khair Therapeutic Services CIC), Dr Misbah Ali (Muslim Doctors Association), Monowara Gani (Sound Heart Clinic & Muslim Charities Forum), Dr Aliyah Abbas (Medical Director, at Aimmune Therapeutics), Hajera Memon (Shade 7 Publishing), Nasima Khanom (Islamic Psychology Professional Association), Dr Omar Shareef (British Islamic Medical Association), Rahmana Chowdhury (My Counsel), Sakoon Counselling, Zohra Khaku (Muslim Youth Helpline), Rizwan Yusoof (National Zakat Foundation) and Talat Baig (Inspirited Minds)- for providing the encouragement, advice and guidance for our research on young, British Muslims.

I would like to particularly acknowledge the role and support shown by Nuzhat Ali (Public Health England Muslim Network & Muslim Women of Merton), Myira Khan (Founder, Muslim Counsellors and Psychotherapists Network) and Safura Loughton (Founder, Lantern Initiative) for being an active supporters and partners in building the foundation of this report.

My sincere and heartfelt gratitude to the University of East London (UEL) for hosting our conference 'Mental Health and Well-being of Young Muslims' in 2019 which enabled us to hold vital discussions and elicit expert contributions for this report. A huge thank you to Professor Aneta Tunariu (Head of Psychology, UEL) and her team, especially Ardiana Meha, for your partnership, fulsome support and immense contribution to this report. Thank you to Shabir Randeree CBE (Chairman at DCD London and Chair of the Board of Trustees at the Woolf Institute, Cambridge), Mr Geoff Thompson MBE FRSA DL (Chair of the Board of Governors, UEL) for your opening remarks and facilitation.

Thank you to our conference speakers and contributors: Dr Ghazala Mir (University of Leeds), Dr Tarek Younis (clinical psychologist, lecturer in psychology at Middlesex University), Prof. Rachel Tribe (UEL), Clare Lyons-Collins (Mental Health Innovation and Improvement at NHS Improvement), Aaliyah Shaikh (Founder, Rahmah Wellbeing Counselling Services), Sheikh Dr Abu Ibrahim, Shalah Akhtar (PwC UK), Dr David Harper (UEL); and panellists: Dr Omar Shareef (British Islamic Medical Association), Dr Misbah Ali (Muslim Doctors Association), Talat Baig (Inspirited Minds), Zohra Khaku (Muslim Youth Helpline), Kathleen Roche-Nagi (Approachable Parenting), for presenting the inspiring and incredible work of your organisations. Thank you for sharing your insights and observations. Thanks, are also due to Dr Gulamabbas Lakha (Oxford University researcher), Sahar Beg (Mind Works UK), Sajda Butt (Mental Health First Aid instructor), Dr Sara Betteridge (Psychologist, Mental Health Activist), Imelda Ryan (Muslim Community Helpline) and all those who helped facilitate group discussions during the conference.

The conference was made possible by a dedicated team who worked with me and assisted with collating valuable data and contributions which provide the backbone to this report. A special thank you to staff at UEL and BCBN supporters and colleagues, Zaynab Hamdi, Mariam Akhtar and Siama Shah.

I am deeply grateful to all the organisations and individuals who shared the survey amongst their networks and public platforms: Everyday Muslims, Muslim Council of Britain, the National Zakat Foundation, Islamic Relief UK, Muslim Charities Forum, Muslim Health Collaborations Network, Inspirited Minds, Muslim Youth Helpline, Muslim News, Emerald Network, Cube Network.

This report would not have been possible with the involvement of our survey participants. For sharing your deep insights, experience and reflections on faith, identity and mental health struggles, I offer my deepest appreciation. Your personal and lived experience is integral to this report which I hope will create further awareness of British Muslim identity and mental health. Your bravery and honesty have been incredibly valuable and humbling.

A number of experts working in the field of mental health have generously provided us with bespoke contributions, speakers from our conference mentioned above and Simon Blake OBE (CEO, Mental Health First Aid England), Poppy Jaman OBE (CEO, City Mental Health Alliance) and Prof McManus (Director of Public Health, Hertfordshire County Council).

There have been many who have engaged and promoted our efforts to conduct research and support mental health causes and initiatives in the Muslim community. There are too many to name individually but your contribution - however big or small-has not gone unnoticed. Thank you for your support and encouragement. We hope you will continue to be a part of this journey and community-wide effort in seeking the betterment of the Muslim community.

Finally, my deepest gratitude to the chairman and founder of BCBN, Tariq Usmani whose trust and belief in our work has made this exploration and endeavour possible. The guidance, support and commitment from our board of trustees has enabled us to seek an evidence-led approach to mental health challenges and barriers faced within the Muslim community, encouraging the community to proactively search for solutions and interventions that foster resilience, confidence and positive role models within our community.

# Introduction

In 2009, the then Labour government put out for consultation its new vision for improving mental health, 'New Horizons: Towards a shared vision for mental health'. In it, it set forth a vision for how services would look a decade into the future: 'In 2020 all individuals will be treated with respect in an inclusive society, whatever their age, background or circumstances...Services will be attuned to the needs and wishes of individuals and communities and will actively promote equality. Inequalities for black and minority ethnic groups in access to and experience of mental health care will have disappeared.'

More than a decade on, we have seen a concerted effort to place a greater onus on mental health and wellbeing alongside physical health in indicators on the health of the nation. The 'parity of esteem' established in the 2011 Coalition Government's mental health strategy, 'No Health Without Mental Health', has enhanced consideration of and attentiveness to mental health in wider strategies for improving health and tackling health inequalities.

Moreover, research over the past decade has increasingly identified the particular problems facing young people in Britain when it comes to mental health and wellbeing. The Government Green Paper, 'Transforming Children and Young People's Mental Health Provision' is indicative of a greater policy focus on the building of resilience and mental health literacy among young people to ensure healthy lives in adolescence and beyond.

Against this backdrop of heightened interest in the mental health of young Britons and an enhanced drive to address and tackle health inequalities, and more than a decade on from the 2009 consultation with its lofty vision of services attuned to the needs wishes of individuals and communities, we are confronted with a lacuna that has a particular effect on young Britons of Muslim background: the deficient consideration of religion in policy discourse, policy initiatives, policy shifts and policy implementation.

While we have been able to identify copious references to race in the policy literature on mental health, with growing awareness of the availability, impact and consequences of service provision for individuals and groups defined by race, references to religion are, by comparison, meagre and sparse. Though we now arguably are more aware of the intersectional nature of identities and impacts of inequality, as experience and outcome, the focus in the area of mental health has been slow to adapt to the growing diversity of the British population and the needs of young Britons of Muslim background who suffer from low levels of wellbeing and poor mental health. As the Covid-19 pandemic has raged through Britain's ethnic minority communities with disproportionately high deaths rates and negative economic impact felt by British Muslims, the neglect of ethnicity and religion in policy discourse and practice is, rightly, under renewed scrutiny.

This report is principally based on the views and experiences of young British Muslims who have accessed mental health services. It provides a unique insight into types of mental health difficulties they experience, the role of faith and community - both positive and negative, the prevalence, or otherwise, of access to mental health services that are culturally competent and religiously literate, and their assessment, as service users, of the quality of services received and its effect on recovery and outcomes.

We welcome the commitment in the Conservative Party election manifesto to "treat mental health with the same urgency as physical health", thereby reaffirming the stances taken by preceding governments. We also take this opportunity to reinforce the significance of the promise to give greater control over their treatment to sufferers of mental health problems so that they may "receive the dignity and respect they deserve".

This report is a contribution to the “greater control” of treatments to Muslim mental health service users in the hope that the experiences they have shared in the course of the conference and survey on which this report is based, may yield positive changes in the dignity and respect afforded to them by statutory services, mental health practitioners and, importantly, from within Muslim communities. We hope it will serve as a useful reminder that mental health problems affect people of all backgrounds and a ‘one size fits all’ approach to services is neither befitting nor beneficial for the individuals and their families who seek mental health support. In the context of underlying health inequalities and disparities evident in the impact of Covid-19 on ethnic minorities, this report highlights the need to address the causes of poor health outcomes among minority ethnic groups by tackling structural racism and negative experiences that deter Muslims from accessing services, as well the importance of faith and culturally sensitive services to improve health outcomes.

Mental health policy in the UK has taken the pattern of decennial development, with consultations and plans devised in 1999, 2009 and 2019, with the publication of the Green Paper on improving mental health provision for children and young people. More recently, the Government has announced its intention to reform mental health legislation with a new Mental Health Bill expected in 2022. Other changes include the introduction of a Patient and Carers Race Equality Framework and “culturally appropriate advocates,” to ensure ethnic minorities get the support and care they deserve, and the development of a Patient and Carers Race Equality Standard by the National Collaborating Centre for Mental Health (NCCMH). These are hugely important and welcome shifts in policy and practice. Reflecting on what has passed before and what must change in the future is essential if policy is to keep abreast of the increased prevalence of low mental health and wellbeing among different groups of young people in society, among them young British Muslims. We present these recommendations as vital steps towards change that is long overdue.

# Executive Summary

- The most common mental health struggles faced by young Muslims were anxiety (53.8%), depression (49.4%) and stress (48.6%).

- More than half of young people who have experienced mental health struggles say they have turned to friends, (52%), followed by family (30%) and seeking help through therapy (20%). Nearly one in five (18%), said they had turned to no one when undergoing difficulties. The importance of mental health literacy within Muslim communities cannot be emphasised enough, particularly in relation to peer and family support when it comes to signposting and referring for help.

- Nearly one in five young Muslims said they had harboured suicidal thoughts "many times" (19%). An almost equal number said they had done so "sometimes" (18%) and about a quarter said they had "occasionally" experienced suicidal thoughts (24%).

- Faith plays a positive role in supporting mental wellbeing among young Muslims with the majority of participants, (59%) agreeing that it does. Among those who have experienced mental health struggles, the figure is higher at 81%.

- More than half of young Muslims are likely turn to faith when experiencing mental health struggles with more young Muslim men saying they are likely to do so (61%), compared to young Muslim females (56%).

- For young Muslims who have experienced counselling or therapy, the figures are marginally higher with 63% saying they are likely to turn to faith when experiencing mental health struggles.

- Nearly two in five young Muslims say they would prefer to see a Muslim counsellor or therapist, (39.5%). Among those who have experienced counselling, this rises to more than one in two, with 55% of service users saying they would prefer to see a Muslim counsellor or therapist. There is a strong association between experiencing counselling and preferring to see a Muslim counsellor or therapist with a correlation coefficient of r=0.997*.

- Three in five young Muslims (61%) say it is important to them that mental health services display cultural/faith sensitivity. Among those who have experienced counselling, there is a much higher tendency to attach such importance with nearly 90% saying it was important that mental health services are culturally/faith sensitive.

- For young Muslims who have experienced counselling or therapy, there is a statistically significant association between being a service user and (a) the important attached to mental health services being culturally/faith sensitive and (b) believing faith has a positive role in supporting mental wellbeing with a correlation coefficient in both cases of r=0.997.

- Experiencing mental health struggles and a belief that faith has a positive role in supporting mental wellbeing bears out the strong tendency among young Muslims who view faith as a benevolent tool with a statistically significant association of r=0.91.

- Turning to faith when experiencing mental health struggles and the belief that faith has a positive role in supporting mental wellbeing, shows a further statistically significant correlation of r=1.0.

*The coefficient numbers (r) indicated denote the strength of association between two variables measured on a 0-1 scale where zero indicates a very weak association and one a very strong association. For all the correlations tested in this study, statistically significant correlations were found with the coefficients bearing nearer to 1.

- Faith is seen by young Muslims as a protective factor helping with mental health struggles with religious practice and spiritual beliefs offering a wide range of supportive instruments. For example, through actions such as prayer and stories of the prophets from Islamic sources.

- Guilt was the most common reason cited by young Muslims for faith not helping with both self-induced (shame, ingratitude) and externally directed (blame, censure) guilt having a negative impact on mental health.

- Faith as a risk factor can manifest in external contexts with overt displays of hostility and prejudice to Islam and Muslims and institutional racism playing a part in aggravating mental health challenges faced by young Muslims. Insidious forms of unconscious bias and pejorative value judgements can leave young Muslims feeling ridiculed for their belief in God or having faith and relying on it as a coping mechanism. Greater reflexivity is needed to help to identify, address and challenge the ways in which Muslim identity is problematised in treatment rooms, as much as in wider society, and the (un)intended consequences of this on young Muslims' mental health.

This report tells a story of hidden survivors and missed opportunities across an array of sectors that have bearing on the mental health of young Muslims in the UK. The sectors range from the private - family and parenting - to the communal - religious communities and faith leaders - and to the public - statutory services, mental health practitioners and wider society.

Young Muslims account for half of the British Muslim population with those aged 25 and under making up 50% of the faith group. The missed opportunities found in this report have huge implications for a significant proportion of the British Muslim population and deserve greater attention within Muslim communities. Families, faith leaders, community advocates and religious scholars all have a role to play in addressing the myriad of problems facing young Muslims and championing their needs through mental health literacy, political advocacy and familial and social support.

Religious literacy and cultural competency can make a positive contribution to the treatment of mental health problems. Embedding religious literacy and cultural competency within mental health service provision is of vital importance so that young people can feel understood, respected, accepted, and cared for when seeking help or accessing support.

Faith and spiritual beliefs play an important and positive role in helping young people deal with mental health struggles. Supporting them by normalising the use of a repertoire of religious tools to address mental health struggles should be intrinsic to the implementation of a "person-centred approach" to mental health.

Training, professional development and religious literacy programmes run by specialist providers, such as those offered by the Department of Psychology at University of East London, are fundamental to robustly and holistically examining why, how and when faith can support young people in their mental wellbeing and mental health.

A stated preference for counselling administered by a counsellor or therapist of Muslim background should be seen as an affirmation of the need for better training and inclusion of Muslim professionals working in the mental health sector. Diversity is about more than meeting equality targets, it is about placing the needs of service users at the heart of service commissioning, development and delivery. Organisations like the Muslim Counsellors' and Psychotherapists' Network (MCAPN) can play an important role in facilitating dialogical encounters and exchanges between Muslims working in mental health services and Islamic counselling practices as a means to improve religious literacy in mainstream mental health services.

A more sophisticated discourse on faith and mental health is a necessity not just in the mental health sector but also, crucially, within Muslim communities. Such a discourse should clearly delineate religion from 'culture'. It should also seek to understand culture within British Muslim contexts as a plural phenomenon encapsulating the wide range of ethnicities and nationalities that make up Britain's Muslim communities.

Cultural beliefs and attitudes can both inform and exacerbate mental health problems, and hinder timely

access to treatment and services. A more honest dialogue about cultural beliefs and their impact on the mental health of young Muslims is needed if we are to put young people first and build networks of nurture that support them to lead healthy lives.

Challenging the cultural and social stigma attached to mental health in Muslim communities requires the use of those spaces and places where religious nurture takes place. Mosques as community resources for the promulgation of learning are instrumental to the raising of mental health awareness and mental health literacy in Muslim communities.

Mental health literacy in Muslim communities should get creative and be more expansive drawing on the wealth of information and references in Islamic sources to build a reliable and formidable discourse on human flourishing in Islam. Muslims need to "get their theology talking to science" when it comes to mental health.

Increasing numbers of young Muslims enter British higher education each year and it is vital that universities implement their duty of care in a manner commensurate with the religiously diverse nature of the student population. Mental health support services provided by university institutions must have due regard for faith and cultural sensitivity to ensure Muslim students have access to services that are appropriate to their needs.

Mental health support in the workplace is essential for business and employees alike, and toolkits, such as the Mental Health and Race Toolkit by the City Mental Health Alliance, can help businesses support their ethnic minority employees to thrive in the workplace.

Government plans to introduce a Patient and Carers Race Equality Framework, Race Equality Standard and "culturally appropriate advocates" should take due consideration of religion as well as race when it comes to reforming mental health services, to ensure that they are better designed to deliver an outstanding quality of care to Britain's diverse population.

# Background to this report

In April 2019, the Better Community Business Network organised a one-day conference in partnership with the University of East London, to look at the mental health and wellbeing of young British Muslims by drawing on academic research, statutory services, community practitioners, faith leaders and faith-led psychotherapy services. The conference provided an opportunity to widen the parameters of the agenda on mental health and young people to consider the needs of faith communities and service users of Muslim background.

The conference aimed to:

- Increase awareness of the mental health issues facing Muslim youth and the need for access to culturally and faith appropriate mental health and well-being resources/services;
- Help raise the profile of mental well-being in the Muslim population group;
- Help decrease the stigma attached to mental illness within the Muslim community by creating dialogue and cross sector engagement;
- Share and support evidence-based research on mental health and Muslims;
- Provide a platform for learning, discussion, support and facilitation between statutory services and independent, faith-led provision; and
- Form a set of recommendations for the statutory services, government, researchers, funders and Muslim communities.

The conference programme included a range of lectures from academics researching mental health in Muslim communities and communities of faith more broadly, thus inviting comparative perspectives on the role and visibility of faith in addressing mental health problems in specific sub-group populations. The lectures covered the themes of 'Community psychology, cultural psychiatry and social prescription in addressing mental health' and 'Public health, whole system approaches to mental health and faith', as well as perspectives from independent, faith-led services covering 'Cultural and faith sensitive therapeutic services addressing Muslim mental health'.

The conference programme promoted a deeper engagement with community-based, faith-led services, with a number of specialist providers sharing their experiences of working with young Muslims in mental health service provision in a panel discussion titled 'A community-centric approach to Muslim mental health needs'.

Moreover, the conference programme invited a plethora of expert and practitioner views through a series of discussion with topics such as Cultural and faith sensitive resources and services for Muslim youth, Mental health awareness and reducing stigma in Muslim communities, and Inequalities in mental health: the role of research and development of cultural-sensitive resources.

The group discussions were moderated and a scribe assigned to each one to document the central themes emerging from the discussion. This report draws on the notes taken during these discussions.

Finally, and most importantly, the conference itself was preceded by the circulation of a survey inviting young Muslims to participate in sharing their views and experiences and encounters with mental health services. The survey was analysed using SPSS (quantitative analysis) and NVivo software (qualitative analysis). Further details about the survey analysis can be found in the next section on Methodology.

It was a stated aim of BCBN to gather experts, practitioners, academics and faith-led service providers in the independent and statutory sectors to share their views, research, policy design and implementation to gain a greater insight into the identification and integration of religious and culturally sensitive treatments in mental health services for young Muslims. The conference was an attempt to understand the causes of ill mental health among young Muslims in the UK, and the treatments available that cater for their specific needs.

The conference was an opportunity to analyse inequality of outcomes for Muslim patients using mental health services and to address the ways in which this could be tackled through better informed and widely accessible religious and culturally sensitive services. It was also an opportunity to highlight the exacerbation of mental health problems that arise from within Muslim communities and to talk openly about the roles of family, faith communities, and faith-based institutions when it comes to giving young people the help and support they need to talk about their problems and identify pathways to recovery, and to stand with them through their journey to wellbeing and good mental health.

A report on the conference and an analysis of the survey of young Muslims was commissioned to push forward an agenda focused on the needs of young Muslims and their mental health. A 'person-centred approach' which listens to and learns from the experiences of young Muslims is what is envisaged in the hope that this report can support statutory services, mental health professionals, Muslim families and faith leaders and, importantly, young Muslims themselves, by giving them greater control over the type of treatment they believe can assist them in dealing with their mental health and wellbeing and which they value as instruments for better coping, resilience and recovery.

Lastly, at a time when there are funding cuts to community and youth services and a paucity of interest in the commissioning or applying of research that analyses mental health problems using a religious lens, it is hoped this report will galvanise resources within Muslim communities, in particular, charity and philanthropy, to invest in young Muslims by promoting innovative collaborations and co-production of strategies formed through a partnership between the statutory and independent sectors. As the conference showed, there is already a multiplicity of initiatives in Muslim communities to respond to the growing need of mental health support services for young people and a rising number of advocates for Muslim users in the form of Muslim medical professionals and community-based providers. But segmenting service provision to create parallel structures, in the community and in the mainstream, is neither viable nor desirable. Young Muslims in the UK deserve mainstream mental health services that are more attentive to their needs, in compliance with the equality duties established in legislation and policy goals on reducing health inequalities championed by the healthcare sector. In the midst of this legislative equality framework and public health policy objectives on reducing health inequalities, there is a role for Muslim communities. To bring about change will require a willingness to listen, learn and adapt. We hope the voices of the young Muslim people reflected in this report fosters collaboration between Muslim communities, the independent and voluntary sector, and the statutory sector to drive forward that change.

# Methodology

The findings in this report are based on two modes of analysis of the survey data: quantitative and qualitative. The online survey was designed in consultation with a steering group made up of academics and Muslim mental health practitioners and shared by Better Community Business Network. The survey was distributed to a number of individuals and organisations involved in the planning of the conference and with other outlets, organisations and online platforms that attract a young Muslim audience. Organisations and individuals with whom the survey was shared include the following: Zaynab Hamdi (BCBN), Safura Loughton (Lantern Initiative), Nuzhat Ali (Public Health England, Muslim Women of Merton), Myira Khan (MCAPN), Dr Aneta Tunariu (UEL, Head of Psychology), Sadiya Ahmed (Everyday Muslims), Muslim Council of Britain, National Zakat Foundation, Tufail Hussain (Islamic Relief UK), Muslim Charities Forum, Javed Patel (Muslim Health Collaborations Network), Inspirited Minds, Muslim Youth Helpline, Ahmed Versi (Muslim News), Rooful Ali (Emerald Network), Syed Rahim (Cube Network).

The survey ran between April and June 2019 and was highlighted during the conference itself to increase take up. Given the sensitivity of the subject matter and the exploratory nature of the research sought by BCBN, survey respondents were invited to complete as much of the survey as they felt comfortable with. Respondents were permitted to withdraw at any point in the survey, or to skip questions they felt uncomfortable answering. This was consciously embedded in the survey format to allow young people the freedom to provide only that information they were prepared or willing to submit. A total of 729 respondents responded to the survey. Informed consent was obtained from all participants within the survey prior to submitting results.

The survey elicited responses from individuals aged 18 to 30 who self-identified as Muslim and currently reside in the UK. Over 80% of survey respondents disclosed their age, gender and ethnicity. Around a quarter were aged 18-21 (24.36%), over a third 22-25 (36.46%) and the largest proportion aged 26-30 (39.18%). More than three quarters of respondents were female (76%) and just under a quarter male, (24%) with one respondent describing their gender as ‘other’. Throughout the report, the analysis examines variances in responses by age, gender and ethnicity where significant.

The survey captured a wide range of ethnicities, though invariably the dominant group (representing over two thirds of responses) was South Asian: Pakistani (34.07%), Bangladeshi (23.68%) and Indian (13.12%). Other ethnicities reflected in survey respondents were White (2.4%), White Irish (0.17%), Black African (6.64%), Black Caribbean (0.34%) and Arab (8.9%). The Mixed Race category (4.1%) and others, White and Black Caribbean (0.34%), White and Black African (0.51%) and White and Asian, (1.02%). The ‘Other’ ethnic box attracted 0.7% respondents. Again, where responses show degrees of divergence and difference by ethnicity, these have been captured in the quantitative analysis.

The geographic spread of respondents was UK-wide with more than half being from London. Responses were also received from Northern Ireland and, interestingly, more respondents from the South East of England than from the West Midlands, Yorkshire and the North West, areas of the UK with large Muslim populations. The high proportion of responses from London may be explained by the networks and organisations approached by BCBN to disseminate the survey. The high proportion is not of itself a liability given the capital’s diversity within its Muslim population, it being greater than corresponding levels of ethnic diversity in regions with larger concentrations of Muslims, therefore allowing for greater ethnic diversity to compensate for limits to its geographic scope.

Almost nine in ten of survey respondents identified as ‘visibly’ Muslim with more than two thirds of female respondents wearing some form of Islamic dress: hijab (head-covering) (47%), jilbab (long, loose garb) (10.41%) and niqab (face veil) (2.07%). The aspect of being ‘visibly’ Muslim is relevant in so far as the study is interested in both the external factors which can make young Muslims vulnerable to mental health struggles, such as Islamophobia and a heightened awareness of negative perceptions and attitudes towards Muslims

in society, as well as the personal resources identified by respondents as supporting them to maintain good levels of personal well-being and resilience when facing challenges to mental health, among them individual faith and spirituality and the wider social assets of faith-based institutions and organisations.

A number of key questions underpin this study and are informed by BCBN's aims to further understand the needs of young Muslims, particularly those who have experienced mental health challenges.

- What do young British Muslims understand by mental well-being and mental health struggles?
- How do their responses map onto the components of mental well-being, the emotive, evaluative and functioning aspects?
- Does faith and spirituality play a role in what young Muslims consider to be 'good' mental well-being or 'good' mental health? If so, what is this role and why is it important?
- Does the faith identity of a counsellor or psychotherapist make a difference to a Muslim accessing mental health services, and why?
- How important is it to young people for mental health services to be faith and/or culturally sensitive?

The survey made ample use of dialogue boxes (without word limit) to allow young people as much space as possible to explain their reasoning in their own words. Throughout this report, respondents' voices have been captured through direct quotations to give further meaning and insight to the data derived from the quantitative analysis. It is worth noting that where respondents were invited to share any final comments on completing the survey, the most common response was to thank the organisers for offering the opportunity for young people to speak about their struggles openly expressing the hope that their answers would help pave the way for Muslim communities to do more to support young people with their mental health challenges, and help shape better service provision for young people in the future.

# Mental health in a pandemic

There has been much discussion about mental health over the course of the past year, as the UK population has grappled with severe restrictions to ordinary life as a consequence of the Covid-19 pandemic. Since the initial lockdown announcement in March 2020, the onset of the third national lockdown in January 2021, and the intermittent periods of tiered restrictions affecting different parts of the country to varying degrees, Britons have endured limitations to normal everyday life in ways not seen since the Second World War. Enforced working from home, nationwide school closures, exam cancellations, online teaching becoming the go-to method of learning and knowledge dissemination for schools and universities across the country, and widespread restrictions to sectors of the economy, such as hospitality, transport and travel, and leisure industries, these are just some of the extraordinary changes the country has had to come to terms with in a short space of time. In addition, official data revealing the disproportionate impact of the pandemic on ethnic minority communities, with Black, Asian and Other minority ethnic groups bearing the brunt of deaths caused by Covid-19, highlights the differential impact of the pandemic on sections of the population.[1] While the country has faced enormous challenges over the course of the year, certain sections of the UK population have fared far worse than others, a fact that bears great significance to the future mental health and wellbeing of ethnic minority groups.

A growing awareness of the impact of Covid-19 on minority ethnic communities has seen the publication of several reports documenting the disproportionate incidence of serious illness and death among Black, Asian and other ethnic minority groups. The Office for National Statistics has published several reports analysing data by ethnic and religious group with an initial study in June 2020 covering deaths occurring between 2 March and 15 May 2020, and a subsequent study in October 2020 covering deaths occurring during the period 2 March to 28 July 2020. The first analysis provided statistical breakdown by ethnicity and religion while the updated data covered ethnic groups only.

According to the early ONS analysis of deaths caused by Covid-19 by ethnic group, taking into account the size and age structure of the UK population, those in the Black ethnic group were found to have the highest rate of Covid-19 deaths at 255.7 deaths per 100,000 population with the lowest among males of White ethnic background at 87.0 deaths per 100,000. The analysis showed that for all ages the rate of deaths involving Covid-19 for Black males was 3.3 times greater than that for White males of the same age, while the rate for Black females was 2.4 times greater than for White females. After adjusting for region, population density, socio-demographic and household characteristics, the Black ethnic group was found to have an increased risk of death 2.0 higher for males and 1.4 higher for females compared to the White ethnic group. Asian males, those of Bangladeshi/Pakistani and Indian ethnic background, also had a significantly higher risk of death involving Covid-19: 1.5 and 1.6 times, respectively.[2] The initial analysis also provided a breakdown of Covid-19 deaths by religious group where the age-standardised mortality rates (ASMRs) of deaths involving Covid-19 was found to be highest among Muslims, with 198.9 deaths per 100,000 males and 98.2 deaths per 100,000 females. Importantly, the ONS analysis noted that religion was not recorded on the death certificate of those succumbing to Covid-19 and the data excluded anyone under the age of nine. The age-standardised mortality rates for those aged 9-64 and aged 65 and over shows among males aged 9 to 64 years, those identifying as Muslim had a raised rate of death involving Covid-19 compared with all other religious groups, at 46 deaths per 100,000. Among females, those who identified as Muslim, Sikh or Hindu had higher mortality rates compared with the Christian and no religion populations.[3]

1 Public Health England. *Disparities in the risk and outcomes of covid-19.* PHE, 2020
2 Office for National Statistics (ONS). *Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 15 May 2020.* (19 June 2020) https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronaviruscovid19r elateddeathsbyethnicgroupenglandandwales/2march2020to15may2020.
3 Office for National Statistics. *Coronavirus (COVID-19) related deaths by religious group, England and Wales: 2 March to 15 May 2020.* (19 June 2020)

Table 1: Age-standardised mortality rates involving COVID-19 for those aged nine years and over by sex and religious group, England and Wales, 2 March to 15 May 2020.

| | Age-standardised mortality rates involving COVID-19 | |
|---|---|---|
| **Religious group** | **Males** | **Females** |
| No religion | 80.7 | 47.9 |
| Christian | 92.6 | 54.6 |
| Buddhist | 113.5 | 57.4 |
| Hindu | 154.8 | 93.3 |
| Jewish | 187.9 | 94.3 |
| Muslim | 198.9 | 98.2 |
| Sikh | 128.6 | 69.4 |
| Other religion or not stated | 84.2 | 49.2 |

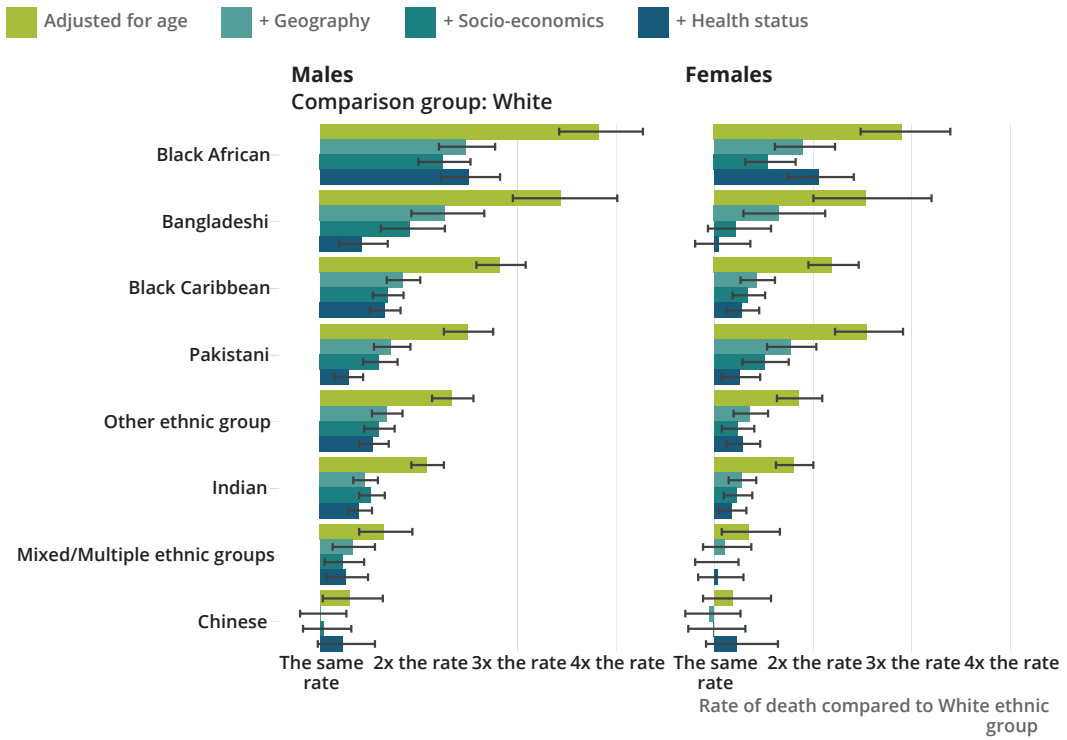
(Source: ONS)

Updated analysis by the ONS study covering the period 2 March to 28 July 2020, found that males and females of Black and South Asian ethnic background were shown to have increased risks of death involving coronavirus compared with those of White ethnic background. Males of Black African ethnic background had the highest rate of death involving Covid-19, 2.7 times higher than males of White ethnic background. Black Caribbean and Bangladeshi males had the second highest rate of death, 2.5 times higher than White ethnic males. Among females, those of Black Caribbean ethnic background had the highest rate of death involving Covid-19, 2.0 times higher than for females of White ethnic background. Females of Pakistani background had the next highest rate, 1.8, followed by Bangladeshi and Black African females, 1.7, respectively.[4]

In the previous study, covering the period to 15 May 2020, the Pakistani and Bangladeshi groups were combined in the ONS analysis. The updated statistical release covering the period to 28 July 2020, in which the groups were independently assessed, found that "these new estimates show the latter (Bangladeshi) had a significantly higher risk of COVID-19 mortality."[5]

4 Office for National Statistics (ONS). *Updating ethnic contrasts in deaths involving the coronavirus (COVID-19), England and Wales: deaths occurring 2 March to 28 July 2020.* (14 October 2020).
https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/updatingethniccontrastsindeathsinvolvingthecoronaviruscovid19englandandwales/deathsoccurring2marchto28july2020
5 Ibid

Figure 1: Rate of death involving the coronavirus (COVID-19) by ethnic group and sex relative to the White population, England, 2 March to 28 July 2020[6]




(Source: ONS)

Further studies have shown ethnic minority groups were more likely to require critical care and invasive ventilation than White patients "despite similar disease severity on admission, similar duration of symptoms, and being younger with fewer comorbidities".[7]

Factors identified as relevant when accounting for the varied impact of Covid-19 on ethnic groups include deprivation, comorbidities, occupational risk, including in healthcare settings, residing in urban areas and living in multi-generational households. Analysis published by the ONS in May 2020, covering deaths occurring involving Covid-19 between 1 March and 17 April 2020, found the age-standardised mortality rate of deaths in the most deprived areas of England was two times higher than for the least deprived, 55.1 deaths per 100,000 population compared with 25.3 deaths per 100,000 population.[8] Ethnic minority groups are over-represented in deprivation indices with 31% of Pakistani, 28% of Bangladeshi, 20% of black African, and 18% of black Caribbean people likely to live in the most deprived 10% of neighbourhoods compared to just 9% of people of White British background.[9]

For Muslims, living in built-up urban areas in some of the most deprived regions in the country, in multi-generational households and working in occupations that pose a greater risk to infection, such as taxi drivers or shopkeepers, are among some of the factors that explain the higher incidence of infection and death from Covid-19. For example, around a third of taxi drivers and chauffeurs are Bangladeshi or Pakistani men placing them at greater risk of contracting the virus.[10]

6 ibid
7 Razai Mohammad S, Kankam Hadyn K N, Majeed Azeem, Esmail Aneez, Williams David R. *Mitigating ethnic disparities in covid-19 and beyond* BMJ 2021; 372 :m4921
8 ONS, *Deaths involving COVID-19 by local area and socioeconomic deprivation: deaths occurring between 1 March and 17 April 2020.* 1 May 2020.
9 Razai Mohammad S, Kankam Hadyn K N, Majeed Azeem, Esmail Aneez, Williams David R. *Mitigating ethnic disparities in covid-19 and beyond* BMJ 2021; 372 :m4921
10 Office for National Statistics. *Why have Black and South Asian people been hit hardest by COVID-19?* (14 December 2020). https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/articles/whyhaveblackandsouthasianpeoplebeenhithardestbycovid19/2020-12-14

The updated ONS analysis does not include a breakdown by religion, limiting our ability to assess the impact on Muslims to ethnic proxies using data for the Pakistani and Bangladeshi groups only. This neglects the Arab ethnic group, for example, which is included in the ONS reports under 'Other ethnic group', as well as Muslims of other ethnicities such as Indians, Somalis, Nigerians, Mixed ethnicity etc. British Muslims are one of the most diverse religious groups in the UK and use of data on ethnicity to assess the impact of Covid-19 on Muslims as a group is strongly deficient, particularly given the diminishing proportion of British Muslims who are of Pakistani or Bangladeshi background. Although recommendations to record ethnicity data on death certificates have increasingly been noted since the publication of the ONS reports and those by Public Health England,[11] as well as regional analysis such as that commissioned by the Mayor of London, Sadiq Khan,[12] recognition of religion as a protected characteristic and more comprehensive data collection on religion by public sector bodies continues to be an area of deep concern for British Muslims.

The relevance of religion and the need for better recording and monitoring of data on self-declared religious identity have come to the fore during the pandemic, with numerous examples of where religious groups, religious institutions, or faith-based organisations have been instrumental to policy implementation concerning community transmission and public health guidance. This has been the case since the outset with the introduction of the Emergency Coronavirus Bill in March 2020 highlighting the importance of religious rights in matters relating to death and burial rites.[13] It has also been evident in the pre-emptive action by British mosques to suspend congregational prayers before the announcement of the first national lockdown on 23 March 2020 and their resolve to do the same when regions were placed under Tier 4 regulations, such as happened in London and the South East in December 2020. Moreover, the use of faith-based organisations and religious leaders in information dissemination throughout the pandemic, such as issuing public health guidance in minority languages and, in more recent days, in challenging myths about the Covid-19 vaccine to tackle low uptake rates in minority communities, has been of vital importance.[14]

These new burdens on religious leaders and institutions have occurred at a time when Muslims, like other faith groups, have had to grapple with changing regulations concerning the use of places of worship commensurate with social distancing guidelines; an issue which has only compounded the difficulties experienced by many in Muslim communities with the palpable loss of support structures to cope with painful issues such as bereavement, funeral restrictions and trauma due to Covid-19. The effects have also been seen in other aspects of religious life with Muslims experiencing two Ramadans in lockdown states, in April and May 2020 and 2021.

Given the reliance on religious institutions and faith leaders, both by government and public health agencies and, crucially, local communities, it is disappointing that analysis of the impact of Covid-19 on minority groups has not been more comprehensive when it comes to data analysis by religious groups. The role of faith-based organisations in public health campaigns and targeted communications strategies throughout the pandemic has been highly visible and well received. In contrast, attention to the needs of faith communities has been noticeably weaker. The more comprehensive the data, the better use that can be made of it by faith communities, policymakers and health professionals to identify and address those factors that put certain minority groups at greater risk of illness and death. For Muslim leaders and faith-based organisations, data by religious group serves multiple uses: community-awareness of the impact on Muslims and advocacy to articulate policy changes needed to address those factors that have greater salience in relation to Muslims as a group, to help tailor their communications in various ethnic languages, and to support their communities better in terms of pastoral care. This is an issue of present and future significance especially when we consider the other areas of life where the pandemic has had a greater negative impact on minority groups.

11 *Beyond the data: Understanding the impact of COVID-19 on BAME groups*, Public Health England, June 2020
12 Professor James Nazroo, Karl Murray, Harry Taylor, Dr Laia Bécares, Yvonne Field, Dr Dharmi Kapadia, and Dr Yansie Rolston. *Rapid Evidence Review: Inequalities in relation to COVID-19 and their effects on London.* Manchester, Centre on Dynamics of Ethnicity, 2020.
13 Hansard HC Deb. Vol. 674 Col. 138-140, 23 March 2020.
14 Harriet Sherwood, Imams across UK to reassure worshippers about Covid vaccines. *The Guardian*, 14 January 2021.

Employment and financial resilience are significant areas in which minority groups have fared worse than others according to recent polls and labour market analysis. A poll conducted by YouGov in August 2020 found that Black, Asian and minority ethnic groups were more likely to have suffered a drop in household income due to Covid-19, with 36% of those of BAME background saying their income had been reduced compared to 28% of those of White background. Minority groups were also more likely to report a negative impact on their personal financial situation, household financial situation, regular household expenditure, amount of disposable income, and savings and debts, as a result of the pandemic compared to White people with more than two in five (41%) people of Black, Asian and minority ethnic background stating they were worried about losing their job as a result of Covid-19 compared to around a third (34%) of people of White background.[15]

An ONS report published in December 2020 found that certain ethnic groups were much less likely to be able to withstand a sudden loss of more than three months' employment income. Those of Black African or Other Black ethnicity were significantly less likely (27%) to have assets to cover a loss in income of more than three months than households from the White British (52%), Other White (49%) and Indian (58%) ethnic groups. Households with heads from the Black Caribbean and Pakistani or Bangladeshi ethnic groups were also less likely to have the resources to cover such an income shock, 32% and 35% respectively.[16]

Moreover, according to the TUC, employees of BAME background have borne the brunt of job losses during the pandemic, with employment among minority groups dropping 26 times more than for employees of White background. The employment rate for Black, Asian and minority ethnic workers dropped by 5.3% in the year to September 2020, compared with a 0.2% decrease in the number of employed white workers. Frances O'Grady, TUC general secretary, noted that "In every industry where jobs have gone, BME people have been more likely to be made unemployed."[17]

Taking these figures together with the abovementioned data on the incidence of Covid-19 mortality rates among males of Black and Pakistani or Bangladeshi background, and the higher rates among women of Black and Pakistani or Bangladeshi background, we can surmise that the economic impact of Covid-19 on minority households will be profound, with many families in these communities facing up to the prospect of losing income earners as well as falling household income due to unemployment.

For young people, the data appears even bleaker. Analysis of changes to the labour market since the onset of the pandemic shows that young people have been the hardest hit due to forced closures to sectors of the economy such as retail, leisure and hospitality. The Institute for Fiscal Studies assessed that employees aged under 25 were about two and a half times as likely to work in a sector that has been closed due to lockdown. Women are also more likely to have been affected given the high proportion that work in retail and hospitality sectors.18 The IFS noted "women were about one third more likely to work in a sector that is now shut down than men: one in six (17% of) female employees were in such sectors, compared to one in seven (13%) of male employees."[19]

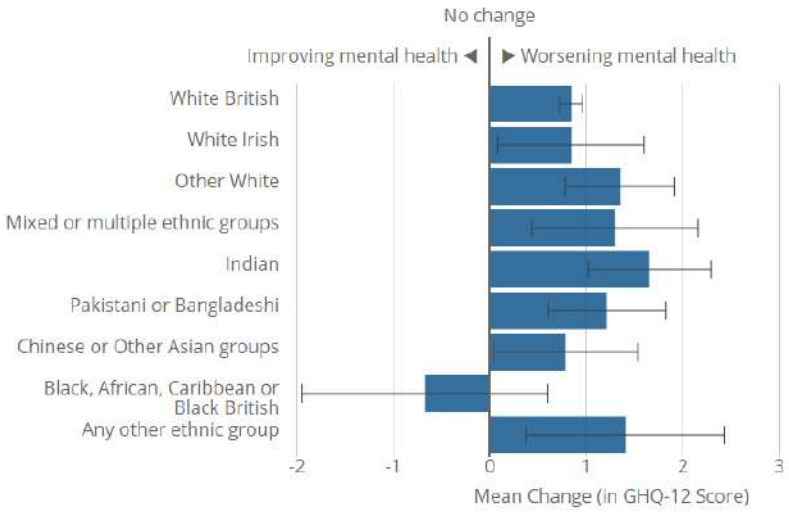
Unsurprisingly, the ONS report highlights the worsening levels of mental health among minority groups using results from the General Health Questionnaire (GHQ-12) in its study on the social impacts of coronavirus on different ethnic groups in the UK. After adjusting for age, sex, socio-economic classification, change in help and support received since the start of the coronavirus pandemic, and whether they have a health condition, the mean scores for the various ethnic groups shows that those in the Indian ethnic group reported a greater average increase in GHQ-12 scores (1.7), followed by Any other ethnic group, 1.4, Mixed or multiple ethnic groups, 1.3 and Pakistani or Bangladeshi, 1.2. Lower scores were reported by White British, 0.9, White Irish,

15 YouGov Debt tracker poll, August 2020. Available at:
https://docs.cdn.yougov.com/pwxlnivscd/Debt%20Tracker%20-%20clean%20data.pdf. Last accessed: 20 January 2021.
16 Office for National Statistics. *Coronavirus and the social impacts on different ethnic groups in the UK: 2020:* Estimates from the Understanding Society: COVID-19 Study, 2020, UK Household Longitudinal Study (UKHLS) and Wealth and Assets Survey (WAS) to explore the social impacts of the coronavirus (COVID-19) pandemic on people from different ethnic groups in the UK. (14 December 2020).
17 Phillip Inman, 'Black, Asian and minority-ethnic UK workers hit worst by Covid job cuts'. *The Guardian*, 19 January 2021.
18 Robert Joyce and Xiaowei Xu, Sector shutdowns during the coronavirus crisis: which workers are most exposed? *Institute for Fiscal Studies.* (London: April 2020)
19 Ibid

0.9, Chinese or Other Asian ethnic groups, 0.8 (see Figure 2).[20]

The Mental Health Foundation which has been conducting a UK-wide, long-term study of how the pandemic is affecting people's mental health, in partnership with the University of Cambridge, Swansea University, the University of Strathclyde and Queen's University Belfast, has undertaken analysis in successive waves beginning from mid-March, just before the first national lockdown. In its most recent wave, the Foundation found "Nearly half (46%) of the UK population are worried about the mental health of their child(ren) and how this is being impacted by the pandemic; three in ten (29%) are worried about making their own existing mental health difficulties worse; and the proportion of adults who think that their own future will be worse are higher for people aged 18-24 (61%), those with pre-existing mental health conditions (62%) and full-time students (67%).[21]

Figure 2: Fully adjusted average change in GHQ-12 scores of those aged 16 years and over between 2019 and April 2020 by ethnic group, UK, 2019 and April 2020. [22]




(Source: Understanding Society: COVID-19 Study, 2020)

20 Office for National Statistics. *Coronavirus and the social impacts on different ethnic groups in the UK: 2020:* Estimates from the Understanding Society: COVID-19 Study, 2020, UK Household Longitudinal Study (UKHLS) and Wealth and Assets Survey (WAS) to explore the social impacts of the coronavirus (COVID-19) pandemic on people from different ethnic groups in the UK. (14 December 2020).
21 Mental Health Foundation, Coronavirus: *Mental Health in the Pandemic, Wave 9: pre-Christmas 2020*. Available at: https://www.mentalhealth.org.uk/wave-9-pre-christmas-2020. Last accessed 29 January 2021.
22 Ibid

The impact of Covid-19 and the ensuing economic uncertainty on young people's mental health, wellbeing, and optimism about future prospects is laid bare in two reports published by The Prince's Trust. The research shows young people not in education, employment or training (NEETs) suffered higher levels of mental ill-health. Though the age range studied by The Prince's Trust does not correlate directly with the age groups analysed in this survey, the overlap among young adults (18-25 years) is a relevant area of interest.

In 'Lockdown 2020', polling conducted in April/May 2020 among 16–25-year-olds found that over a quarter of young people 29% felt their future career prospects have already been damaged by the coronavirus pandemic, with 46% saying finding a job now feels "impossible". Nearly half of young people (49%) worry that it will be harder than ever to get a job. More than two in five young people (43%) said their anxiety levels increased due to the pandemic, with almost a third (32%) saying they were "overwhelmed" by feelings of panic and anxiety on a daily basis. More than half (54%) of those who said their anxiety had increased during the first national lockdown attributed this to concerns about future work and income, while 40% put their anxiety down to being unable to see family. [23]

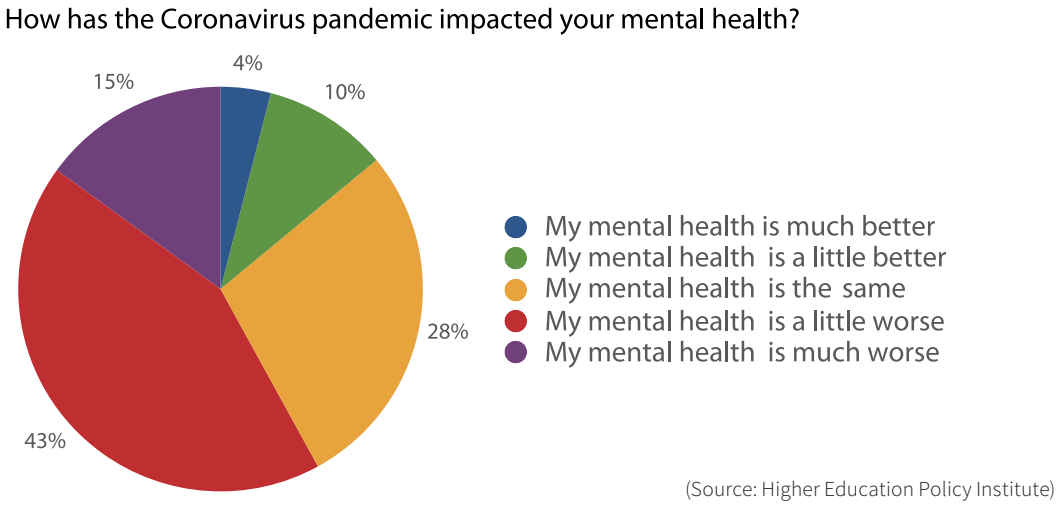
In the 'Youth Index 2021' report, The Prince's Trust found that half (50%) of 16–25-year-olds said their mental health had worsened since the start of the pandemic, with almost a quarter of young people (23%) stating they did not feel confident about their future work. Since the start of the pandemic, one in five young people (21%) have experienced suicidal thoughts, rising to 28% of NEETs, 10% of young people have self-harmed, increasing to 14% of NEETs, and more than one in five 22% have experienced panic attacks, compared to 28% of NEETs.[24]

For young people in full time education, the Student Academic Experience Survey (SAES) 2020 offers some insights into whether the pandemic has had an impact on students' wellbeing and mental health. The survey notes the declining trend in the four measures of wellbeing assessed by the ONS (life satisfaction, life worthwhile, happiness and low anxiety), with the figures reported in 2020 falling in all categories bar low anxiety, which saw a slight increase. The survey shows students continue to report lower levels of wellbeing than 20–24-year-olds in the general population across all measures (See Table 5). [25]

23 The Prince's Trust, *Young People in Lockdown: A report by The Prince's Trust and YouGov.* (May 2020).
24 The Prince's Trust, *The Prince's Trust Tesco Youth Index* (January 2021).
25 Jonathan Neves and Rachel Hewitt, *Student Academic Experience Survey 2020.* Advance HE and Higher Education Policy Institute: June 2020.

Two surveys conducted in November 2020 found worsening mental health among the student population during the pandemic. A poll by the Higher Education Policy Institute (HEPI) found that more than half of students 58% said their mental health was worse because of the pandemic with 14% saying it was better and the remaining 28% saying it had stayed the same.[26] The Coronavirus Student Survey phase 3, conducted by the National Union of Students (NUS), found that 52% of respondents described their current mental health and wellbeing as worse compared with their life before the pandemic. Just over a third (35%) described it as the same, 8% as better and 4% refused.[27]

Figure 3: Students' views on the impact of Coronavirus on their higher education experience in 2020/21




(Source: Higher Education Policy Institute)

The HEPI study further noted the level of student satisfaction with the provision of mental health services at their higher education institution, with around two in five (42%) saying they were very or quite satisfied with the provision of these services and around one in five students (22%) saying they were very or quite unsatisfied with the provision.[28]

26 Rachel Hewitt, *'HEPI Policy Note 27: Students' views on the impact of Coronavirus on their higher education experience in 2020/21'.* (Higher Education Policy Institute: December 2020)
27 NUS Insight, *Coronavirus Student Survey phase III: Mental health and wellbeing.* NUS: December 2020.
28 Rachel Hewitt, *'HEPI Policy Note 27: Students' views on the impact of Coronavirus on their higher education experience in 2020/21'.* (Higher Education Policy Institute: December 2020)

According to the NUS study, 69% of students had not sought any mental health support, with only 29% of those who said their mental health had worsened due to the pandemic seeking out support. Of those who had sought support with mental health and wellbeing, 57% said they were very or somewhat satisfied with the support they had received and 19% saying they were very or somewhat dissatisfied. Types of support students expressed an interest in accessing included "access to a counsellor, someone to talk to, online support and support from institution".[29]

The NUS study also provides an interesting point of detail regarding black, Asian and ethnic minority respondents to the survey with students of minority background among groups more likely to agree with the statements: "I am concerned about my own wellbeing" and "I am concerned as to whether I have the tools and skills to manage my own wellbeing."[30]

It goes without saying that the figures outlined in this report regarding mental wellbeing and mental health struggles pre-date the pandemic. With current research showing the rising levels of anxiety, stress, depression and manifestation of serious illness, it is highly likely these figures will have increased since the survey was undertaken.

Mental health and wellbeing have been a persistent concern over the past year, with mental health charities reporting a huge surge in calls and demand for services.[31] The ONS has regularly tracked national wellbeing week to week, identifying rises and falls in levels across its four metrics and assessing the changes against pre-pandemic levels. The aforementioned Mental Health Foundation project is similarly engaged in long-term trends analysis of the impact of the pandemic on the population's mental health. With a third national lockdown being implemented, economic uncertainty persisting, schools and universities vacillating between long periods of online teaching and a return to a face-to-face learning environment, still rising fatalities and ongoing research exploring the deleterious impact of 'Long Covid' on sufferers, as well as the enormous physical, mental and emotional strain on medical and healthcare professionals on the frontline, it would be unwise to undermine the extent of the 'mental health crisis' that awaits us.[32] Dr Adrian James of the Royal College of Psychiatrists notes from comparable analogies of disasters and other pandemics that the "mental health effects roll on for about 18 months to two years afterwards".[33] The Centre for Mental Health has predicted that up to 10 million people – almost a fifth of the population – will need either new or additional mental health support as a direct consequence of Covid-19.[34] The forecast demonstrates the immense scale of mental health support that will be required in the future as the full social, economic and mental health impact of the pandemic gradually materialises.

The disproportionate impact of Covid-19 on ethnic minorities has seen a revived push to focus public health policy on the social determinants of health and structural racism.

Recognising the underlying health inequalities which have exacerbated the pandemic's toll on minority ethnic groups and the prevalence of "negative experiences within a culturally insensitive healthcare service [which] may create barriers, inhibit access to healthcare, and influence healthcare seeking behaviours among ethnic minority groups",[35] tackling the social determinants of health and addressing the institutional arrangements that aggravate poor health outcomes among minority groups has taken on a much greater sense of importance since the onset of the pandemic.

29 NUS Insight, *Coronavirus Student Survey phase III: Mental health and wellbeing.* NUS: December 2020.
30 Ibid
31 'Mind warns of 'second pandemic' as it reveals more people in mental health crisis than ever recorded and helpline calls soar', *MIND*, 13 November 2020.
32 Roberta Heale and Alicia Grooms, 'Is a Crisis in Mental Health the Next Pandemic?'. *British Medical Journal Blog*, 4 October 2020. Available at: https://blogs.bmj.com/ebn/2020/10/04/is-a-crisis-in-mental-health-the-next-pandemic/. Last accessed: 20 January 2020.
33 NHS mental health beds are full, Royal College of Psychiatrists warns, *ITV News,* 29 January 2021.
34 Nick O'Shea, 'Covid-19 and the nation's mental health: Forecasting needs and risks in the UK. *Centre for Mental Health,* October 2020'.
35 Razai Mohammad S, Kankam Hadyn K N, Majeed Azeem, Esmail Aneez, Williams David R. *Mitigating ethnic disparities in covid-19 and beyond* BMJ 2021; 372 :m4921

With mounting evidence of the disproportionate impact of Covid-19 on minority groups, it is inevitable that among those seeking either new or additional mental health support will be people from Muslim backgrounds. During the pandemic, Muslim mental health support charities have been vigilant to the rising demand for mental health support in their communities. The Muslim Youth Helpline reported a 313% increase in calls during the first lockdown in March 2020 with a sharp increase in the number of calls relating to suicidal feelings. MYH noted comparative figures for January - March and April – August with 26 enquiries related to suicide/suicidal thoughts in the first quarter of last year and a much higher number of 87 enquiries in the period during and after the first lockdown.[36] The Muslim Council of Britain established ten 'Covid Response Groups' (CRG) to marshal expertise and advocacy from within Muslim communities during the first wave, including a Mental Health CRG. The group is made up of a consortium of organisations including Inspirited Minds, Muslim Counsellors and Psychotherapists Network (MCAPN), Muslim Youth Helpline (MYH), Sakoon, British Islamic Medical Association, Muslim Women's Network UK (MWNUK), MindWorksUK and Approachable Parenting with the group organising monthly webinars to support communities and coordinating the work of Muslim-led mental health organisations.

Another notable intervention to support minority communities is the Mental Health and Race Toolkit developed by the City Mental Health Alliance (CMHA) to help businesses support employees from Black, Asian and other minority ethnic background.[37] The Toolkit highlights four key targets for businesses: Challenge all forms of racism in the workplace, Build inclusive and representative mental health and wellbeing support, Allocate Board level responsibility, and Measure progress. The Toolkit comes with practical suggestions on how to achieve the strategic actions with examples from businesses that have taken firm steps to build mentally healthy workplaces such as Lloyds Banking Group's Race Action Plan and PwC's representative mental health awareness campaign. In light of the foregoing ONS and IFS analysis on the sectors of the economy in which minority groups have been hardest hit by Covid-19, either where they face an increased risk of infection or where they are more likely to be exposed to economic hardship, the CMHA Toolkit illustrates just how important it is for businesses to play their part when it comes to supporting Black, Asian and other minority ethnic employees. These are but a few examples of the ways in which Muslim-led mental health charities and organisations have been responding to the steep escalation in demand for their services. Given the forecast by the Centre for Mental Health, their steady but significant support is going to be in much greater demand in the future.

When this study was first conceived in 2019, we could not have envisaged the massive changes to the landscape in which the findings of our analysis would become acutely relevant and timely. We could not have foreseen the sharp rise in mental health needs in Muslim communities nor could we have anticipated the enormous disruption to lives and livelihoods that young people have faced over the past year. It was always our stated desire to shine a light on the mental health struggles of young British Muslims and, through the sharing of their experiences and insights, advocate for better targeted interventions and support systems to help them address their struggles and enable them to live healthy, flourishing lives. As the pandemic has raged over the past year, leaving minority groups suffering multiple negative impacts, there has been a renewed interest in health inequalities, structural racism and better data collection, monitoring and analysis on race, religion and gender to enable clearer insights to emerge on the causes of differential health outcomes for ethnic minority groups. The creation of the NHS Race and Health Observatory in June 2020 and the publication of the 'Advancing mental health equalities strategy,' by NHS England in September 2020, are illustrative of how our healthcare system is now acutely aware of and responding to the needs of Britain's diverse population when it comes to health outcomes and provision of services, especially as Covid-19 has thrown a spotlight onto health disparities in ethnic minority communities. We hope this study on the mental health struggles of young British Muslims can find a place within this nexus where a new focus on improving health outcomes for minority groups, tackling structural racism and discrimination in healthcare settings,

36 Sakinah Abdul Aziz, *'Together in Tribulation: British Muslims and the COVID-19 Pandemic'*. Muslim Council of Britain, 2020. p 24
37 Stuart Gentle, 'The City Mental Health Alliance launches Toolkit to help UK businesses support the mental health of employees who are Black or from a Minority Ethnic background'. *OnRec*, 12 January 2021. Available at: https://www.onrec.com/news/launch/the-city-mental-health-alliance-launches-toolkit-to-help-uk-businesses-support-the. Last accessed: 25 January 2021.

and enhancing data recording mechanisms sits alongside widespread recognition of the need for more funding for increased mental health support in the years to come. It is our hope that the agenda to tackle health disparities, improve health outcomes, and recognise the cultural and other factors that influence resilience and health-seeking behaviours in Muslim communities will benefit from the insights shared in this report.

# No health without mental health

The following section offers an overview of policymaking on mental health over the last decade. It details the emerging focus on children and young people, as prevention and early intervention takes on a decidedly clear role in mental policy and service delivery as seen in the recently published Green Paper, 'Transforming Children and Young People's Mental Health Provision'.

**Mental health and 'parity of esteem'**

The publication of the Coalition Government's 'No Health without Mental Health' strategy in 2011 ushered in a new impetus in relation to mental health by establishing as a key objective the attainment of a 'parity of esteem' between mental health and physical health.

Building on the White Paper published in the preceding year, 'Healthy Lives, Healthy People' and the launch of the National Wellbeing Programme in 2010[38], the new mental health strategy brought enhanced rigour to the improvement in access to services, measuring the impact of treatments, and broadening the scope of mental health policy to go beyond diagnosis and treatment to encompass early intervention and tackle societal stigma which can impede individuals talking about their problems and seeking timely help.

No Health without Mental Health refers to the mainstreaming of mental health by emphasising the fundamental contribution wellbeing makes to physical health. Analysis of wellbeing on physical health observes a number of positive effects including improved recovery from illness, its association with positive health behaviours in adults and children, such as effects on smoking, physical activity, obesity and diet and alcohol and drug consumption in adults and in children, its association with fewer risk behaviours among 15- to 17-year-olds, physical activity, and moderating effect on excessive levels of screen time on mobile devices. High levels of wellbeing have also been associated broader positive outcomes such as positive influences on the wellbeing and mental health of those close to us, protecting against developing illness, rates of healing from wounds and the likelihood of recovering and surviving an illness.[39]

Good mental wellbeing has various health policy implications for example, on treatment decisions and costs, on local services and on averting adverse health problems by promoting cost-effective strategies to improve mental wellbeing. The opportunity cost of poor mental wellbeing is a higher healthcare burden.

People with mental illness die, on average, 16-25 years sooner than the general population and research suggests subjective wellbeing, measured as individual's assessment of life satisfaction (evaluation), positive emotions (hedonic), and whether an individual feels their life is meaningful (eudemonic), can add 4-10 years to life expectancy. Co-morbidity, which measures causal relationships between factors affecting general health, finds a 50% increased morbidity risk among those who suffer from depression. Mental health is, as recent evidence on measuring wellbeing suggests, crucial to good physical health.[40]

The No Health without Mental Health policy therefore sets out objectives for assuring a 'parity of esteem between mental and physical health services' and helping to ensure parity of experience with people with physical ill health.[41] The strategy adopts a 'life course approach' noting that the 'foundations for lifelong wellbeing are already being laid down before birth, and that there is much we can do to protect and promote wellbeing and resilience through our early years, into adulthood and then on into a healthy old age.'[42]

38 PM speech on wellbeing. Prime Minister's Office, 25 November 2010. Available at: https://www.gov.uk/government/speeches/pm-speech-on-wellbeing. Last accessed: 1 February 2020.
39 Wellbeing: Why it matters to health policy. Department of Health, 2014.
40 No Health Without Mental Health: a cross-government outcomes strategy, Department of Health and Social Care, 2 February 2011
41 ibid
42 ibid

The strategy identified early intervention as a key plank of the policy with childhood and teenage years of 'crucial' importance to 'prevent mental illness from developing and mitigate its effects when it does.'[43]

The six shared objectives laid out in the strategy were:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination.

The 2011 strategy, coming a year after the enactment of the Equality Act 2010, makes copious references to the necessity of action on mental health, addressing health inequalities and the particular impacts and outcomes for different social groups, including those defined by race and religion or belief. The strategy highlights the inequalities of access and outcomes for minority groups and, further, presents a positive case for engaging an individual's religious identity as a means of achieving greater engagement with services and positive outcomes.

Recognising the wider social environment that can augment and exacerbate mental conditions in people of minority backgrounds, the 'No Health without Mental Health' strategy sets key targets for addressing inequality between groups as:

- tackling the inequalities that lead to poor mental health;
- tackling the inequalities that result from poor mental health – such as lower employment rates, and poorer housing, education and physical health; and
- tackling the inequalities in service provision – in access, experience and outcomes.

Moreover, consistent with the newly enacted Equality Act, the strategy noted the prospect of services either falling foul of indirect discrimination or reinforcing disparate inequalities between groups by cautioning that 'all protected characteristics should be considered so as to avoid unjustifiable discrimination.'[44]

For its time, the strategy maintained a commendable interest and focus on religion and belief. Noting the existence of data revealing that 'more people from BME backgrounds identify themselves as religious', the strategy clearly posited the benefits of service response integrating religion and belief to better meet the needs of minority groups.

The strategy noted the myriad ways in which religion or belief can impact on patient experience, from the use of language that could impede a mutually intelligible discourse for talking about mental health issues, to the protective facets of religious belief when it came to prevention, recovery and outcomes. The strategy referred to the 'potential for people who hold religious or other beliefs to have poorer experiences of services because core aspects of their identity are overlooked or they have no means of religious expression (for example, prayer rooms). This may cause anxiety and prove detrimental to their recovery.'[45]

43 ibid
44 ibid
45 ibid

On the question of language and access to services, the strategy referred to 'the role of religion or belief in people's explanations for their mental health problems – different conceptualisations and language between an individual and services will affect engagement and success of treatment and care.'[46]

Enabling the expression of religious belief, the strategy noted that for positive outcomes to be achieved 'services will need to incorporate religion and belief into the assessment of individuals' and that 'local services will achieve better outcomes if they make resources and facilities available for people to express their religion or belief.'[47]

Furthermore, the strategy set out a number of measures by which those commissioning or delivering services to mental health service users could attend to the needs of diverse communities in the form of local collection and monitoring of information on ethnicity and culture; the better use of data to inform commissioning and provision in health and social care; a focus on outcomes that work for individuals and communities by taking into consideration the specificities arising from the characteristics of individuals and communities; monitoring and evaluation of the effectiveness of service delivery, especially around equality needs; and establishing mechanisms that allow local user groups to engage with providers and commissioners, and that empower and support them so that they can engage effectively.[48]

It is fair to say that the 2011 strategy recognised and championed religiously literate mental health service provision on the twin basis of tackling health inequalities and advancing positive outcomes for patients and their families, by taking full consideration of all aspects of an individual's identity and culture in the development of a person-centred approach.

Early responsibility for the delivery of the strategy was placed at the door of the Mental health strategy Ministerial Advisory Group which had a cross-government approach, working with statutory bodies and community and voluntary sector organisations to forge a partnership focused on accountability and change. The strategy identified key bodies integral to the delivery of the strategy: the NHS Commissioning Board, and Public Health England, the two of whom would later take principal ownership of the reducing health inequalities agenda, with GP consortia, the Local Government Association, the Association of Directors of Adult Social Services, the Association of Directors of Children's Services, other government departments, the Care Quality Commission, Monitor, professional bodies, commissioners, mental health provider organisations, the voluntary and community sector, and people with mental health problems and carers.

The ambition of the strategy and the whole system approach incorporating national, regional and local bodies working together with input from the public and service users, and with its particular attention to the needs of diverse groups, created a laudable framework within which the 'no decision about me without me' ethos could be realised.

A growing focus on prevention and early intervention saw the publication in 2015 of 'Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing', informed by the work of the Children and Young People's Mental Health and Wellbeing Taskforce. The taskforce included the work of a subset group tasked with examining issues for Vulnerable Groups and Inequalities. Similar to the work of the MHT, the group identified common themes in relation to access, interventions and outcomes for people from minority and other marginalised groups.[49]

46 ibid
47 ibid
48 ibid
49 Vulnerable Groups and Inequalities Task and Finish group Report, Children and Young People's Mental Health and Wellbeing Taskforce. March 2015. Available at:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414326/Vulnerable_ Groups_ and_Inequalities.pdf

The Five Year Forward View on Mental Health (FYFV), developed by the Mental Health Taskforce (MHT), built on the vision set out in the 2011 strategy document placing a "life course" approach at the heart of the five-year plan to encompass mental health provision from "access, outcomes and experience throughout the mental health pathway". The approach set out plans to improve provision from prevention and first contact with services, to diagnosis, treatment, optimising quality of life and providing crucial support for those living with complex and longer-term mental health conditions.[50]

Included in the terms of reference of the MHT was "address[ing] equality and human rights commitments relating to the mental health of our population".[51] The MHT initiated a widescale public engagement to elicit information about experiences of mental health services from a range of social groups, and in particular those largely excluded from public consultation exercises such as minority ethnic communities. An online survey carried out by Mind and Rethink Mental Illness solicited 20,473 responses. The survey was also complemented by community engagement events with Black, Asian and minority ethnic groups to compensate for the significantly low rate of response to the online survey from these groups. Of the final sample of more than twenty thousand survey responses, two% (the lowest of all ethnic groups represented in the sample) were from people who identified as being of Black or Asian ethnic groups.

Among results emerging from the quantitative and qualitative analysis of the survey data was the focus among ethnic minorities on accessibility for marginalised groups, targeted support for groups currently experiencing low access and poor outcomes, tackling stigma associated with mental health in minority communities, and increasing the range of interventions available for people to choose from. Two notable findings from the survey analysis include the championing of a 'community asset' approach, with tangible benefits accruing from working with community and voluntary sector organisations, including faith-based organisations, to equip people with knowledge and skills to understand and manage their own mental health and that of those close to them, and the desire for staff training across the NHS in cultural competency, with a preference for the training to be led by people who have used mental health services.[52]

Themes which recur throughout the policy strategies which have a bearing on young Muslims are equality and human rights assessments when it comes to interventions, access to services and addressing inequalities in outcomes, stigma within communities which affect timely access to services and stigma without, that is, discrimination in service provision which can have both cause and consequences effects with people from minority groups disengaging from services and suffering the worsening of conditions as a result. The emphasis in the various strategies on cultural competencies in the approach to diverse communities and continuous professional development of NHS staff to maintain knowledge and expertise when it comes to treating people from minority communities persist in the various consultations, taskforce subgroups and policy documents in the past decade.

Further evidence of the Government's determination to listen to service users and incorporate their encounters with and experience of mental health services, including those from marginalised groups, can be seen in the Government response to the MHT's consultation in which it commissioned, for the first time, a Care Quality Commission-led thematic review of children and young people's mental health services.[53]

50 Mental Health Taskforce: A Five Year Strategy for Mental Health, Terms of Reference. NHS England, 29 October 2015. Available at: https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/10/mh-tor-fin.pdf
51 ibid
52 The Five Year Forward View Mental Health Taskforce: public engagement findings. A report from the independent Mental Health Taskforce to the NHS in England, September 2015. Available at:
https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/09/fyfv-mental-hlth-taskforce.pdf
53 Are we listening? A review of children and young people's mental health services. Care Quality Commission, 6 August 2019

# Mental health among children and young people

Research shows that half of all mental health problems are established by the age of 14, with three quarters established by the age of 24.[54] The shift to a focus on preventative strategies and working with schools to support young people experiencing mental health difficulties, as well as building resilience in young people to withstand and navigate adverse events, is evident in the 2019 Green Paper. Among changes to be introduced to support young people through early diagnosis and access to treatment will be the introduction of new senior mental health leads in schools and mental health support teams working with schools under the supervision of NHS staff.

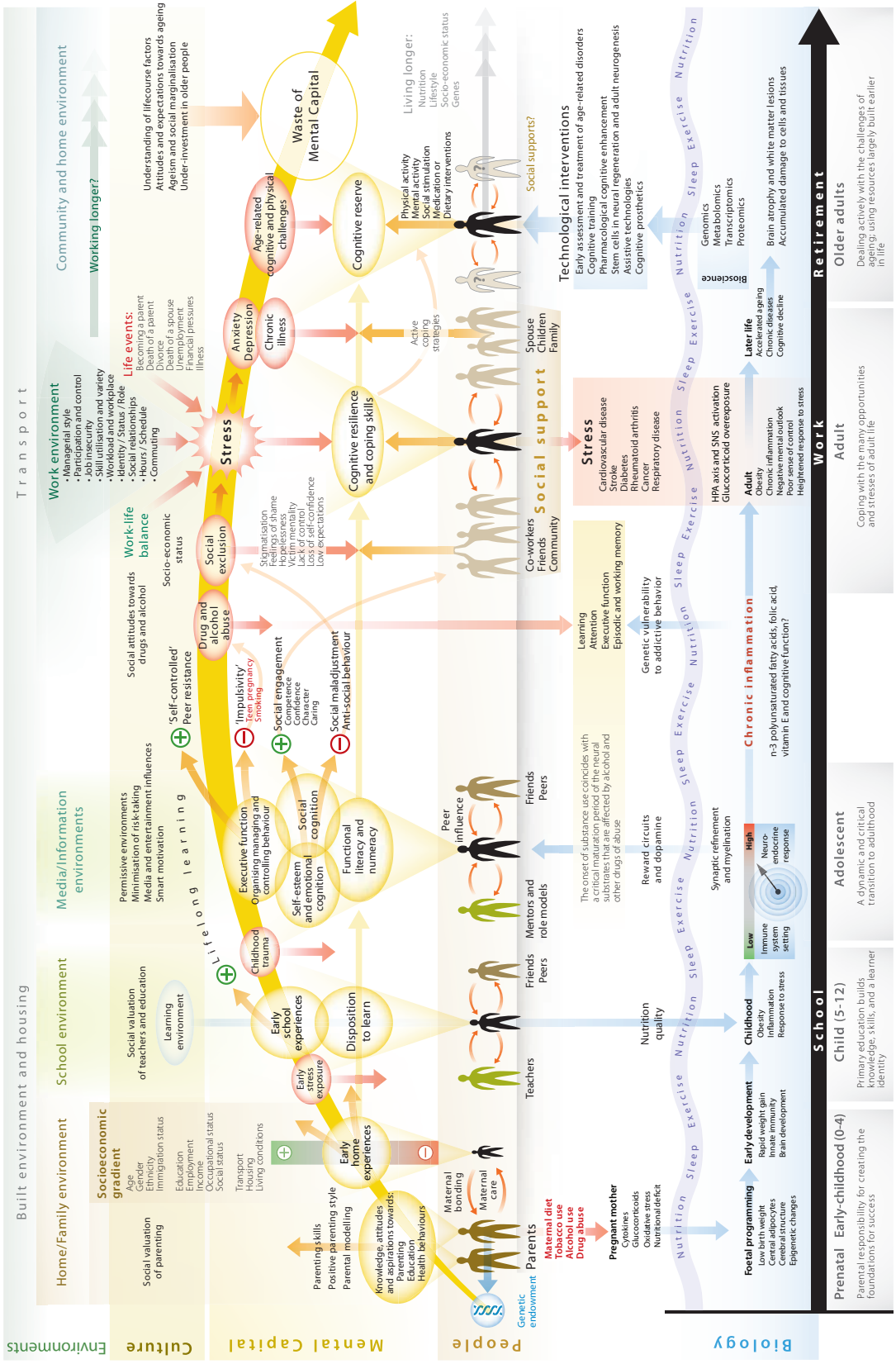
In 2014 and 2015, the government committed to providing an additional £1.4 billion of funding specifically to transform children and young people's mental health services.[55] In 2017–18 NHS England and local groups spent around £1 billion on children and young people's mental health services.[56] Moreover, of the promised £20 billion investment in real terms in the NHS to 2023/24, one tenth, or £2 billion has been earmarked for mental health services.[57]

Mental health illnesses are a leading cause of health-related disabilities in children and young people and can have debilitating and long-lasting effects resulting in poor physical health, low educational attainment, low employment prospects and dysfunctional or troubled social relationships. The cumulative adversities can further magnify the probability of alcohol abuse, smoking and drug misuse in adulthood contributing to a vicious cycle in mental health, physical health, quality of life and emotional well-being.

The illustration overleaf shows the life course of mental health with key junctures that present opportunities for supportive interventions in pre-natal, early childhood, adolescence, adulthood and later life and the classification of the myriad of factors impinging upon mental health over time. The illustration is taken from the Government Office for Science final report on 'Mental Capital and Wellbeing: Making the most of ourselves in the 21st century'. The study, published in 2013, offers a futures-oriented analysis for improving mental health in the UK against a range of domestic, international and technological factors that will affect the mental health of Britons. Factors analysed include the demographic age-shift, changes in the global economy and the world of work, the changing nature of UK society, changing attitudes, new values and expectations of society, the changing nature of public services and new science and technology.

55 Transforming Children and Young People's Mental Health Provision: a Green Paper. Department of Health, December 2017.
56 Mental health services for children and young people. Committee of Public Accounts, HC 1593, 11 January 2019.
57 Mental health spending in the English NHS, Full Fact, 17 May 2019

Figure 4: The trajectory of mental capital through life




(Source: Foresight Mental Capital and Wellbeing Project, Final Project report, 2008)

An independent study by researchers at the Nuffield Trust typifies the trend in young people suffering from ill mental health, noting a six-fold increase in the number of children and young people in England reporting a long-standing mental health condition between 1995 and 2014 (up from 0.8% to 4.8%). Among young adults between 16 and 24, the increase is greater still with figures rising tenfold from 0.6% to just under 6%.[58]

According to figures published by the NSPCC in May 2018, based on Freedom of Information responses from NHS trusts in England, the number of referrals by schools in seeking mental health treatment for pupils had risen by more than a third over the three-year period from 2014/15 to 2017/18. Over half of school referrals were from primary schools, 56%, and an average of 183 referrals per school day were made in 2017/18.[59]

The trend is seen most acutely in the detailed analysis available in the Children and Young People Mental Health surveys of 1999, 2004 and 2017 which allow for comparative analysis between young people from different backgrounds and well as analysis of trends over time. The research shows the incidence and prevalence of emotional, behavioural, hyperactivity, and other types of mental disorder among children and young people with the age groups assessed varying across the three periods of the research. were assessed in 5 to 15 year olds in 1999, 5 to 16 year olds in 2004, and 5 to 19 year olds in 2017.

A recent survey into the mental health of children and young people found that the number of five to 15 year olds with a mental disorder has increased over time: rising from 9.7% in 1999 and 10.1% in 2004 to 11.2% in 2017.[60] The 2017 survey on mental health in children and young people widened the parameters of analysis, extending the age range to cover children aged 5 to 19 (previous phases examined children aged 5 to 15 year olds in 1999 and 5 to 16 year olds in 2004). The research reveals different levels of prevalence by type of disorder, with the highest being emotional disorders and the least prevalent being other types of disorder such as eating disorders or autism.

According to the 2017 figures, one in eight (12.8%) 5 to 19 year olds met the criteria for at least one mental disorder, with overall rates of disorder between boys (12.6%) and girls (12.9%) being broadly similar, although rates were highest in girls aged 17 to 19 (23.9%).[61] The figure shows an increase from the 1 in 10 children experiencing a mental health disorder in the 2004 survey.

The most commonly occurring disorder was emotional, with one in twelve (8.1%) 5 to 19 year olds having an emotional disorder such as anxiety or depression. This was more common in girls (10.0%) than boys (6.2%), and rates increased with age. Rates in 5 to 15 year olds increased between 2004 (3.9%) and 2017 (5.8%).[62]

The second most prevalent disorder was behavioural or 'conduct' disorders, with one in twenty (4.6%) 5 to 19 year olds experiencing them, and a prevalence rate higher among boys than girls, 5.8% and 3.4% respectively.[63] The rate for 5-15 year olds has remained stable. Figures for older children are not available for comparison with previous periods due to the extension of the 17-19 age group in 2017 only and not in the preceding two surveys.

About one in sixty (1.6%) 5 to 19 year olds had a hyperactivity disorder and around one in fifty (2.1%) 5 to 19 year olds was identified with another type of disorder, such as an eating disorder or autism.[64]

58 Dougal Hargreaves, *Minds matter: time to take action on children and young people's mental health.* Nuffield Trust, 11 September 2018. Available at: https://www.nuffieldtrust.org.uk/news-item/minds-matter-time-to-take-action-on-children-and-young-people-s-mental-health
59 Haroon Siddique, Mental health referrals in English schools rise sharply. *The Guardian*, 14 May 2018.
60 Mental health of children and young people in England, 2017: Trends and characteristics. NHS Digital, 22 November 2018.
61 ibid
62 ibid
63 ibid
64 ibid

The research reveals variations by age, sex and ethnic group. Other factors identified in the research as having causal effect on prevalence were demographics, socioeconomics, health and family. According to the research, growing up in a low-income household or having a parent in receipt of income-related benefits was associated with higher rates of mental disorder in children; children with poor general health, special educational needs, or children with a parent with poor mental health or in receipt of a disability-related benefit were more likely to have a mental disorder than other children and children, living in households with less healthy family functioning showed higher rates of mental disorder.[65]

While the 2017 survey finds 5 to 19 year olds of White British background were about three times more likely (14.9%) than Black/Black British (5.6%) or Asian/Asian British (5.2%) children to have a disorder, the ethnic categories vary significantly from the 1999 and 2004 surveys with the use of broad categories (White, Black/Black British and Asian/Asian British) as opposed to the disaggregation by ethnicity occurring in the previous two surveys. The differences in data collection are covered later in the section of equality and religion or belief as a protected characteristic.

The socioeconomic factors affecting mental health in children and young people has been well documented elsewhere, with studies such as the British Medical Association briefing 'Health at a Price', noting the intergenerational cycle of mental health impacts with increased levels of child poverty having a direct negative effect on children's social, emotional, and cognitive outcomes, thus making them more likely to experience poverty as adults.[66] In addition, adverse childhood experiences (such as growing up in environments of neglect, abuse or domestic violence) are more common in areas of higher social deprivation and can increase the risk of mental illness throughout life.[67]

The intergenerational effect is further evident in data from the 2007 and 2014 Adult Psychiatry Morbidity Survey (APMS) which shows employed adults are less likely to suffer from a common mental health problem than those who are not in work.[68] Unemployment is also associated with an increased risk of suicide.[69] Duration of unemployment is also a factor, with depression and anxiety being between four and ten times more prevalent among people who have been unemployed for more than twelve weeks.[70] Children growing up in households with adults in long term unemployment are at greater risk of developing mental health problems which can persist in the next generation, affecting their own children.

The lasting impact of mental disorders occurring in childhood and adolescence have also been documented with evidence of the effect Adverse Childhood Experiences can have on future mental health and wellbeing outcomes.[71] A British cohort study showed that teens who suffered from common mental disorders (CMDs) were over two and a half times more likely to have a CMD at age 36, compared with mentally healthy teenagers. For teenagers with persistent CMDs, the likelihood of having a CMD at age 36 was six times more likely and four times more likely at age 53.[72]

65 ibid
66 British Medical Association. Health at a price: Reducing the impact of poverty. BMA: June 2017.
67 Hughes K, Bellis M, Hardcastle K et al (2017) The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet* Vol 2, Issue 8, PE356-E366, August 01, 2017
68 Stansfeld S, Clark C, Bebbington P et al (2016). Chapter 2: Common mental disorders in S. McManus, P. Bebbington, R. Jenkins, & T. Brugha (Eds.), *Mental health and well-being in England: Adult Psychiatric Morbidity Survey 2014.* Leeds: NHS Digital.
69 Milner A, Page A and LaMontagne AD (2013) Cause and effect in studies on unemployment, mental health and suicide: A meta-analytic and conceptual review. *Psychological Medicine,* 44, 909-917.
70 Royal College of Psychiatrists (2008) *Mental Health and Work.* Royal College of Psychiatrists
71 Transforming Children and Young People's Mental Health Provision: a Green Paper. Department of Health, December 2017.
72 ibid

The survey results are indicative of the individual health, economic and social benefits of early intervention, with research showing that young people with mental health problems are more likely to experience problems in their future employment, with various longitudinal studies suggesting long-term impact on economic activity, welfare support, income, and continuous employment. Moreover, young people with behavioural disorders are more likely to engage in criminal activity, with research suggesting they are 20 times more likely to end up in prison, and four times more likely to become dependent on drugs, compared to the general population.[73] Breaking the cycle through early intervention is therefore essential to steer a course that can have a dramatic and positive impact on the full life course of those exhibiting mental disorders at an early age.

Yet, despite the growing policy focus and financial resources dedicated to improving mental health among children and young people, significant challenges remain in the commissioning of services, the scale of provision falling short of actual need and the role of young people in the designing of interventions in a way which honours the undertaking of 'no decision about me without me'.

Freedom of Information responses gathered from NHS Trusts by the charity Young Minds[74] found that "less than 1% of the total NHS budget and around 8% of the total mental health budget is spent on Child and Adolescent Mental Health Services[75].

Furthermore, published statistics on access to services and waiting times for those referred through primary care for mental health consultations show other challenges to the stated goals of transforming mental health services for children and young people. The limitations of the new provisions are laid bare in the coverage of schools with support teams due to be rolled out to between one-fifth and a quarter of the country by the end of 2023. The mental health support teams located in schools and colleges will be supervised by NHS staff for the purpose of early intervention and ongoing help for children and young people.

Cuts to local authority spending on services for young people is an added challenge to the intended transformation of mental health services for children and young people, particularly in relation to the support structures in local communities that can encourage wellbeing in settings that are supportive of but not formally part of mental health services.

Data compiled by the Chartered Institute of Public Finance and Accountancy (CIPFA) found an 18% drop in local authority spending on services for young people in England in the four-year period covering 2014/15 - 2017/18.[76]

The cuts represent "a wider pattern of prioritising acute need over preventative services" according to Graham Atkins of the Institute for Government, and demonstrate the wider context of diminishing resources to provide informal environments and opportunities for young people to talk about their problems and seek help before problems develop requiring formal modes of treatment through mental health services. The loss of youth centres, parks and recreational services, and afterschool programmes for young people can place a greater budgetary burden on acute social care services, as young people are left without avenues to seek help and support before displaying conditions that require specific or specialist care services.[77]

73 ibid.
74 YoungMinds calls for all STPs to prioritise children's mental health. Young Minds, press release, undated. Available at: https://youngminds.org.uk/about-us/media-centre/press-releases/youngminds-calls-for-all-stps-to-prioritise-children-s-mental-health/
75 Data taken from NHS England, Five Year Forward View for Mental Health Dashboard, Q1 & Q2 2017/18; the NHS Digital, Mental Health Services Data Set, April-May 2018; and responses to YoungMinds Freedom of Information requests. Data refers to 2016-17 the last year for which full figures were available
76 Dominic Brady, Council spending on young people's services drops 18%. Public Finance, 7 March 2019.
77 ibid

Though improvements to children and young people's mental health services are envisaged under the Green Paper, the proposals have met with some criticism regarding the scope of support and the promised resources, which appear to be ill-matched to the scale of the task ahead. The rollout of mental health support teams and designated mental health leads in the number of schools to be covered between 2022-23 is estimated to be in the region of a fifth to a quarter[78]. The more fundamental task of recruiting staff to the health sector to deliver the breadth of the service aspired to over the coming years, however, remains an ongoing challenge. Figures reveal that in 2017/18 only three in ten children and young people with a mental health condition received NHS-funded treatment. The embedding of mental health support in schools can contribute to early intervention models but with a quarter to a fifth of schools likely to benefit from the roll out, the number of children likely to fall through the gap is considerable.

The NHS Five Year Forward View aims to increase the proportion of children and young people with a diagnosable mental health condition who access NHS funded treatment from a calculated baseline of 25% to 35% by 2020-21. This equates to an estimated increase of 70,000 children and young people accessing services per year, by 2020-21. But even if the target is met, the fact remains that two-thirds of children will not have access to NHS-funded treatment.

Charities working on young people and mental health have highlighted the deficiencies in the plans set out to improve mental health outcomes for young people. Whether it is the funding resources made available by government, the method of funds distribution and spending patterns by Clinical Commissioning Groups or the absence of young people in the service delivery design set out in Local Transformation Plans, charities have, in their submissions to various select committee reports, identified a number of recommendations to ensure the extra funding is spent in ways that can achieve the best outcomes for young people.

For example, an assessment of NHS Trusts' Sustainability and Transformation Plans (STPs) published by the charity Young Minds revealed a significant lack of visibility of children and young people's mental health priorities within the plans. Young Minds rated three-quarters of the plans (77%) as having "poor visibility" or "partial visibility" on their commitment and strategy to increase access to children and young people's mental health services.[79]

What all of this means for young people of Muslim background is what we turn to next.

78 Transforming Children and Young People's Mental Health Provision: a Green Paper. Department of Health, December 2017.
79 YoungMinds calls for all STPs to prioritise children's mental health. Young Minds, press release, undated.

# Young British Muslims

Muslims possess the youngest age profile of all religious groups in the UK. The 2011 Census, though now a decade out of date, still provides the most comprehensive data available on the profile and characteristics of the British Muslim population. In 2011, Muslims made up 4.8% of the UK population. More recent analysis using the Annual Population Survey and the Labour Force Survey shows the growth in the size of the Muslim population since 2011. ONS data tables compiled using the APS and LFS from 2016, puts the%age of British Muslims at 5.3%, a 0.5% increase on the 4.8% recorded in the 2011 Census.[80]

Young Muslims make up almost half of the UK Muslim population with 48% being under 25 years of age in 2011. Of this, a third are aged 15 and under.[81] One in twelve schoolchildren in the UK are of Muslim background. Muslims make up 8.1% of all school-age children (5 to 15 years old), with variations in parts of the country with a high local Muslim population such as the London Boroughs of Tower Hamlets and Newham where nearly two thirds (65.8%), or a half (44.1%) of children of school age are of Muslim background. More than three quarters of British Muslims (76%) live in four inner city conurbations: Greater London, West Midlands, North West and Yorkshire and Humberside. The youthful age profile of the British Muslim population is also a factor in the younger age profile of the UK's most diverse cities, where the majority of British Muslims are concentrated. For example, the median age in the city of Birmingham is thirty-two, while in London it is thirty-three, compared to the median age of forty across the UK.[82] The younger age profile makes early intervention and school-focused strategies of acute relevance to Muslim communities.[83] But it also bears significance for the growth and prosperity of the UK's major cities where wellbeing and workforce profile is inextricably linked to the size of the local Muslim population.

Moreover, the geographic concentration of Muslims in certain wards and local authority districts around the country renders Local Transformation Plans by NHS Trusts and the work of local Health and Wellbeing Boards of greater significance in areas where their impact is likely to be keenly felt by Muslim populations.

The 2011 Census also points to the growing ethnic diversity within the Muslim population, with Asians accounting for a diminishing proportion of Muslims compared to the previous census. In 2001, just over a quarter (26.3%) of British Muslims were not of Asian background but by 2011, this had risen to almost a third (32.4%). The growing ethnic diversity within Muslim communities has strong implications for data collection which privileges ethnicity over religion, or uses broad ethnic categories, when it comes to compiling service user profiles at local and national level. As seen above, the shift away from the disaggregation of ethnic group data in the Children and Young People Mental Health Survey 2017 obscures the possibility of detecting trends over time affecting Pakistani and Bangladeshi young people. As ethnic diversity within the British Muslim population increases, clearly identifying factors related to religion, ethnicity and culture and its impact on addressing health inequalities becomes more important for the design and delivery of services that are matched to the demographic profile of local service user populations.

80 Office for National Statistics, Tables produced using the Annual Population Survey and the Labour Force Survey: ethnicity and religion broken down by country. 19 January 2018.
81 British Muslims in Numbers: A Demographic, Socio-economic and Health profile of Muslims in Britain drawing on the 2011 Census. Muslim Council of Britain, February 2015.
82 The Missing Muslims: Unlocking British Muslim Potential for the Benefit of All. Citizens Commission on Islam,. Participation and Public Life, Citizens UK, 2017, pg 21
83 ibid

## *Young Muslims, identity and belonging*

Census and survey data consistently point to the strong attachment to British identity felt by Muslims and their sense of 'loyalty' to the UK. More than half of Muslims (57%) described their national identity as 'British-only', slightly lower than Sikhs (62%) but higher than Hindus (52%), in the 2011 Census. And in a survey conducted by ICM in 2016, 93% of Muslims polled said they felt they belonged to Britain, with more than half saying they felt this "very strongly". In an earlier ICM survey in 2015, 95% said of Muslims polled said they felt loyal to Britain.

Minority groups' attachment to national identity and the persistence, or otherwise, of minority group affiliation and identification is explored in the paper by Professor Lucinda Platt, commissioned as part of the UK Government's Foresight project, entitled 'Future Identities: Changing identities in the UK – the next 10 years'.[84]

Using data from the Citizenship Survey, the Understanding Society longitudinal survey and the Ethnic Minority British Election Study, Platt explores the trend among minority ethnic groups in relation to minority and majority identities. The research reveals that, while secularisation as a trend will affect all groups in British society, among Muslim communities the trend would have the slowest effect.[85] According to the research, religious nurture and the transmission of religion from one generation to the next is high among Muslims, with other research showing that Muslim children are more likely than those of other faith groups to profess the same religion as their parents over time.[86] Platt notes "religious affiliation and religiosity do appear to be relatively strongly transmitted among Muslims, and from high initial levels. There is thus a substantial degree of persistence over the generations, and secularisation will be a slow process for some groups, Muslims in particular."[87]

But the persistence of religious identity in second and subsequent generations of British Muslims does not necessarily entail consistency in patterns of observance, with Platt noting that those who continue to assert strong religious identities in the second generation may find that the "meaning or implications of their religiosity" is different from the first generation.[88]

Nor does the persistence of religious identification suggest a weakening or substitution of the majority identity, Britishness. Indeed, as Platt observes, the "maintenance of dual identities, ethnic origin ties, and strong religious commitment are clearly not felt to be at odds with national belonging or represent 'separation'."[89]

Though second and third generation British Muslims, as other groups, were more likely to report integrated, assimilated or marginalized identities compared to the first generation, second and third generations are also more likely than the first to be 'marginalised' (have weak minority and majority identities). This finding coheres with other research which shows older Muslims are more likely to strongly feel part of British society than younger ones, with two in five (39%) Muslims aged 16-34 saying they strongly agree they feel part of British society compared to over half (57%) of those aged 55 and above who say they strongly agree. However, younger Muslims are significantly more likely (59%) to prefer full integration in British society than all other age groups.[90]

84 Lucinda Platt, Future Identities: Changing identities in the UK – the next 10 years. Government Office for Science, January 2013
85 ibid
86 Jonathan Scourfield, J., Roz Warden, Sophie Gilliat-Ray, Asma Khan, Sameh Otri. (2013). "Religious nurture in British Muslim families: Implications for social work." International Social Work 56(3) 326–342
87 Lucinda Platt, Future Identities: Changing identities in the UK – the next 10 years. Government Office for Science, January 2013
88 ibid
89 ibid
90 Platt and Nandi use the Berry model to measure psychological acculturation in the UK against two variables, Cultural maintenance (Maximum of strength of identification with father's and mother's ethnic groups) and Contact participation (Strength of identification with being British) with outcomes tested against higher than median or lower than/equal to median measures in the two variables. The four possible identities are: integrated (higher than median for both cultural maintenance and contact participation); assimilated (higher than median contact participation and lower or equal to median cultural maintenance); separated (lower or equal to median contact participation but higher than median cultural maintenance) and marginalised (lower than or equal to median for both contact participation and cultural maintenance). See Nandi, A. and Platt, L. (2012b) How diverse is the UK? How British is the UK? Paper prepared for the 2012 Research Methods Festival and to be published as a working paper in the ISER/ Department of Quantitative Social Science working paper series, in 2012.

The apparent disparity between wanting to integrate and feeling a part of British society is explored by Platt with her research showing how disaffection among younger generations can emerge from a sense of the majority identity not being "accessible".[91]

Ali's research on identities and sense of belonging among British Muslims found that 'Britishness' and 'Belonging to Britain' held two key meanings for Muslims: a 'cultural' feeling (being at ease) and an 'affective' feeling (feeling attached). But while one facet of belonging, that of feeling attached, may be stable, something polling data attests to, the other could oscillate between high and low levels contingent on the degree of reciprocity and acceptance from the majority group. That is, Muslims' feeling at ease does not operate in a void but interacts and responds to reciprocal feelings expressed by their fellow citizens recognising and accepting their attachment as legitimate and true.[92]

Platt notes that younger generations in minority groups experiencing a "heightened perception of inequalities in treatment and in life chances" and among whom there is "less connection with their minority identity" may find themselves in a marginalised position in terms of identity and belonging. Platt further warns of the "likely consequences for their psychological wellbeing" arising from the marginalised status for second and third generations among minority groups, including Muslims.[93]

A strong sense British identity can sit alongside a lived experience for minority groups where discrimination and prejudice, with its damaging prospects for equality of opportunity or equality as outcomes, can weaken their sense of belonging. The resulting 'marginalised' status, where the majority identity is inaccessible and minority group identity "devalued" can portend to problems for the psychological wellbeing of minority groups. At the same time, a strong attachment to minority identities, and the persistence of a strong religious identity can provide marginalised groups with opportunities to evince "politicised assertions of identity that aim to mobilise common experiences across those discriminated against". Embracing a "devalued" identity can thus be a means to both overcome a marginalised status and to improve accessibility to the majority identity by advocating for a model of integration that values identification with both the majority group as well as a strong attachment to minority identity.[94]

Religion is also a more potent identifying factor for Muslims than either ethnicity or nationality. Survey data shows that half of Muslims (51%) claim to feel more Muslim than Black or Asian. A third (33%) feel both equally and just 6% feel exclusively Black or Asian. As to national identity, more than two in five Muslims (43%) say they feel more Muslim than British, compared to just under two in five (39%) who say they feel equally British and Muslim. Equal numbers state exclusive identities, with 6% saying they feel more British than Muslim and the same proportion saying they feel Muslim not British.[98]

Religion plays an important part in the lives and identity of most Muslims in Britain, particularly those who hold graduate level qualifications from a British university. In the 2010 Ethnic Minority British Election Study (EMBES), almost all adult Muslims from the main ethnic minority groups said their religion was important to them (51% extremely important and 43% very important), with not a single Muslim respondent claiming religion was "not important at all."[99]

91 ibid
92 Ali, S. (2013). Identities and Sense of Belonging of Muslims in Britain: Using Survey Data, Cognitive Survey Methodology, and In-Depth Interviews; DPhil. University of Oxford. Available online at https://ora.ox.ac.uk/objects/uuid:2f83a760-1090-406abb59-5478c90c5954
93 Lucinda Platt, Future Identities: Changing identities in the UK – the next 10 years. Government Office for Science, January 2013
94 ibid
95 Kully Kaur-Ballagan, Roger Mortimore and Glenn Gottfried, A review of survey research on Muslims in Britain. Ipsos Mori, 21 March 2018
96 ibid
97 ibid
98 ibid
99 ibid

The importance of religion is even more strongly expressed in younger age groups, with 79% of Muslim 13–14-year-olds saying religion is "very important" to the way they live their life. The attachment to religion is not confined to an identity marker, it is also evident in levels of religious observance. Around a quarter of Muslims (24%) say that at least once a day they attend religious services or participate in religious activities with other people, and more than half (55%) say they do so at least once a week.[100] Variance in levels of participation by age are relatively small, with around the same proportion of 18–24-year-olds and those aged 55+ saying they participate at least weekly: 51% and 53% respectively. When asked, "In the past 12 months, how often did you participate in religious activities or attend religious services or meetings with other people, other than for events such as weddings and funerals?", the lowest rate of response was among 18–24-year-olds (10%) compared to 25-34 (16%), 35-54 (13%) and 55+ (14%).[101]

As Nielsen argues, the label 'Muslim' is not merely a moniker. As a label of self-identification, it describes the role of Islam as a 'master-signifier', playing a clear and substantial role in the everyday lives of Muslims.[102]

Beginning with high levels of transmission of religion from one generation to the next, to the persistence of religion as an important aspect of self-identity in subsequent generations alongside a dual attachment to the majority (national) identity, to levels of religious observance, Islam plays an important role in the lives of young British Muslims. But as Platt observes, while religion itself may remain a constant feature in the lives of younger generations of British Muslims, its qualitative nature may vary from the form of religious expression among the older, first or second generations. It can also move in either direction, with younger generations showing either greater levels of secularisation or a deepening of religious sentiment. As Nielsen cautions, "it is necessary to be aware of the differing factors (social, economic, cultural and generational) which may contribute to vary the application of ideas of Islam … at both the individual and the collective level."[103]

What we can confidently assert is that Muslims, like other majority and minority groups in society, have multi-layered, complex and overlapping identities which do not impinge upon or diminish their sense of Britishness. But, putting individuals' sense of belonging aside, there are external factors which can present unique challenges to young Muslims when it comes to the wider social environment in which their sense of belonging is tested and realised. In their report, The Missing Muslims, the Commission on Islam and Muslims in Public Life, referred to testimonies of young Muslims "growing up in a climate of being 'othered'." [104] The Commission found the impact of discrimination, or fears of being discriminated against, were "actively discouraging participation and contributing to disillusionment with the political process amongst young British Muslims."[105] Though the political process is but one avenue to engage with the majority group, as the section below illustrates, discrimination experienced by Muslims is not confined to the political sphere alone and its consequences, across social, educational and economic spheres can have profound effects on mental health.

## *Young Muslims, deprivation, disadvantage and discrimination*

There have been numerous studies attesting to the cumulative disadvantages experienced by British Muslims. Research on the 'ethnic penalty' and the specific 'Muslim penalty', capturing both racial and religious bases of discrimination in outcomes suffered by Muslims in the labour market, is merely one aspect of the multiple deprivations faced by Muslims in the UK. Muslims suffer from higher rates of unemployment compared to both the general population and other minority groups, with unemployment figures for Muslim women evincing starker differences than those of Muslim men. Only one in five (19.8%) of the Muslim population is in full-time employment compared to more than one in three (34.9%) of the overall population in England and Wales.[106]

100 ibid
101 ibid
103 Nielsen, J.S., 'Muslims in Britain: searching for an identity?', New Community, vol. 13, no. 3, 1987, p. 386.
104 The Missing Muslims: Unlocking British Muslim Potential for the Benefit of All, report by the Citizens Commission on Islam, Participation and Public Life. Citizens UK, 2017.
105 ibid
106 Jacqueline Stevenson, Sean Demack, Bernie Stiell, Muna Abdi, Lisa Clarkson, Farhana Ghaffar and Shaima Hassan, The Social Mobility Challenges Faced by Young Muslims. Social Mobility Commission, September 2017.

Muslim men are twice as likely to be unemployed than men in the general population. The Equalities and Human Rights Commission, in its analysis of equality in Britain over the period 2010-2015, noted "Muslims experienced the highest unemployment rates, lowest employment rates and lowest (and decreasing) hourly pay rates over the period." In a more recent report, the EHRC noted a further decline experienced by Muslims in the employment sector with Muslims worse off in terms of unemployment, rate of employment and with the highest rates of insecure employment in comparison to all other religious groups and those who don't identify with any religion.[107] As employment patterns change with the rise of insecure, contract-based work, it is worth noting the prevalence of insecure employment among Muslims. Pakistani and Bangladeshi people were almost twice as likely as White British people to be in insecure employment and Muslims (18.0%) were around twice as likely to be in insecure employment as Christians and those of no religion in 2016/17.[108] Moreover, in the same period, a high proportion of Muslims compared to other religious groups were represented in low-pay occupations, around a third (33.7%).[109]

Data from the Office for National Statistics featuring ethnicity pay gap estimates for 2018 across different ethnicity groups using the Annual Population Survey reveals that in the period covering 2012 to 2018, Pakistanis and Bangladeshis experienced the lowest median gross hourly pay of all ethnic groups. In 2012, the hourly rate for White Britons was £10.58 compared to £8.58 and £8.29 for Pakistanis and Bangladeshis, respectively. In 2018, the hourly rate for White Britons was £12.03 and for Pakistanis and Bangladeshis, it was £10.00 and £9.60 respectively.[110]

For Muslim women, twice as many (58%) were economically inactive in 2015 compared to all women (27%) though there are strong variations between Muslim women of different ethnic groups; 87% of Somali Muslim women are economically inactive compared to 65% of Pakistani women.[111] Research from Bristol University shows the extent of discrimination faced by Muslim women, noting that they are 71% more likely than white Christian women to be unemployed, even after controlling for factors such as similar language abilities, education, marital status, number of children and strength of religious belief.[112]

Muslim women are also more likely than all other women to be economically inactive due to caring responsibilities, with 18% of Muslim women aged 16 to 74 recorded in the 2011 census as "looking after home and family", compared with 6% in the overall population.[113]

Research by Li and Heath shows how high levels of unemployment can affect the 'life course trajectories' of ethnic minorities when it comes to labour market participation. Using longitudinal data from the Understanding Society dataset between 2009-2014, they find "Ethnic minorities are not only more likely to face unemployment, previous experiences of unemployment also carry more enduring scars for them than for the majority group in terms of reemployment and pay."[114]

The Social Mobility Commission, in its report on The Social Mobility Challenges Faced by Young Muslims, found that "Muslims are excluded, discriminated against, or failed, at all stages of their transition from education to employment (or underemployment/ unemployment)."[115] Unemployment rates for young people of ethnic minority background replicate trends found in the adult population, with young people from ethnic minorities between the ages of 16 and 24 almost twice as likely to be unemployed (23%) as their white peers (12%) despite having similar qualifications.[116]

107 Equality and Human Rights Commission. Is Britain Fairer? The state of equality and human rights in 2018 (2018). Retrieved from: https://www.equalityhumanrights.com/sites/default/files/is-britain-fairer-2018-pre-lay.pdf p. 38 Last accessed: 26 January 2019) p. 47
108 Is Britain Fairer? The state of equality and human rights 2018. Equality and Human Rights Commission, June 2019.
109 ibid p 56
110 Office for National Statistics. Ethnicity pay gap reference tables, 12 October 2020.
111 Joseph Rowntree Foundation, Poverty and ethnicity: Balancing caring and earning for British Caribbean, Pakistani and Somali people, 2014
112 Muslim women much more likely to be unemployed than white Christian women, University of Bristol press release, 15 April 2015. Available at: http://www.bristol.ac.uk/news/2015/april/muslim-women-and-employment.html
113 Jacqueline Stevenson, Sean Demack, Bernie Stiell, Muna Abdi, Lisa Clarkson, Farhana Ghaffar and Shaima Hassan, The Social Mobility Challenges Faced by Young Muslims. Social Mobility Commission, September 2017.
114 Yaojun Li & Anthony Heath (2018): Persisting disadvantages: a study of labour market dynamics of ethnic unemployment and earnings in the UK (2009–2015), Journal of Ethnic and Migration Studies
115 ibid
116 Government announces major programme to tackle inequalities in youth unemployment, Prime Minister's Office press release, 19 March 2018. Available at: https://www.gov.uk/government/news/government-announces-major-programme-to-tackle-inequalities-in-youth-unemployment. Last accessed: 29 January 2019.

The EHRC, in its publication, 'Healing a divided Britain: the need for a comprehensive race equality strategy', notes the worsening situation in the number of long-term unemployed among ethnic minority groups compared to their White peers in the years 2010-2015. In 2015, there were 41,000 16 to 24 year olds from ethnic minority communities in the UK who were long-term unemployed, a rise of 49% since 2010, compared with a fall of 1% in overall long-term youth unemployment and a 2% decrease among young White people.[117]

Furthermore, data from the Annual Population Survey for the period 2014-2016, shows an average of 12.8% of young people (16 to 24 years) were not in employment, education, or training (NEET). In the same period, 16.2% of Pakistanis and 15.0% of Bangladeshis aged 16 to 24 years were not in employment, education or training by ethnicity; the highest of all other ethnic groups (for Black and Mixed ethnic groups, the figures were 13.6% and 14.0% respectively). When broken down by ethnicity and sex, Pakistani males were most likely to be NEET (15.8%), compared to 10.2% for Bangladeshi males. For females, the results are reversed with Bangladeshi females most likely to be NEET (19.2%), compared to Pakistani females, 16.8%. In both cases, the figures for Pakistani and Bangladeshis are the highest of all ethnic groups. The average for all young people who are NEET but are actively seeking employment was 5.6% for the period 2014-2016. Among young Pakistanis and Bangladeshis, the figures are considerably higher, at 8.5% and 7.5% respectively.[118]

Levels of high unemployment experienced by their parents can limit the access to opportunities that might otherwise ease the entry of young Muslims into the labour market and support the transition from full time education into employment. Furthermore, bias evident in recruitment practices can compound their unequal opportunities and further frustrate their ability to break out of cycles of disadvantage.[119]

Just under half (46%) of the British Muslim population live in the 10% of the most deprived local authority districts, and household poverty reaches 50% for Muslim households compared to 18% for the population overall.[120] Around a third of children in the UK live in households in poverty, rising to over half of children in Bangladeshi (57.0%), Black African (55.1%), Pakistani (52.8%) and Other ethnicity (51.1%) households.[121]

According to Income Dynamics data from the Understanding Society survey 2010-2017, children in Asian (27%) and Black (16%) households were more likely to live in households with persistent low income than children of White ethnic background (10%). Asian and Other ethnic groups were least likely to leave low-income households than all other ethnic groups. Leaving low-income households means experiencing a rise in income that sees the household move out of the 'low income' bracket when comparing data between one year and the next.[122]

The effects of poverty are lifelong, with research evidencing its impact on educational outcomes, employment and lifetime earnings. A child living in one of England's most deprived areas is around six times more likely to go to a school rated as 'inadequate' by Ofsted than a child growing up in one of the least deprived areas of the country.[123]

117 Healing a divided Britain: the need for a comprehensive race equality strategy. Equality and Human Rights Commission, August 2016. pg 5
118 Ethnicity Facts and Figures, available at: https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/unemployment-and-economic-inactivity/young-people-not-in-employment-education-or-training-neet/latest
119 Valentina Di Stasio and Anthony Heath, Are employers in Britain discriminating against ethnic minorities?. Nuffield College, Oxford, Centre for Social Investigation, 18 January 2019.
120 Li, Y. and Heath, A. (2015). "Are we becoming more or less ethnically-divided?". CSI Briefing Note n. 10. Available at: http://csi.nuff.ox.ac.uk/wp-content/uploads/2015/03/CSI_10_Ethnic_Inequalities.pdf.
121 Is Britain Fairer? The state of equality and human rights 2018. Equality and Human Rights Commission, June 2019. pg 60
122 A household is in low income if they live on less than 60% of the UK's median (average) income. https://www.ethnicity-facts-figures.service.gov.uk/work-pay-and-benefits/pay-and-income/low-income/latest
123 Ofsted (2018), 'Data View: View regional performance over time'. Available at:
https://public.tableau.com/profile/ofsted#!/vizhome/Dataview/Viewregionalperformanceovertime

Research into educational attainment of Muslim pupils in recent years has shown two significant trends: the greater proportion of Muslim girls attaining grades A* to C in GSCE English and Maths than Muslim boys,[124] and the higher proportion of Muslim females entering higher education than Muslim males.[125] Looking at recent data from the Department of Education on pupil performance at Key Stage 4 (GSCE level) and measuring against deprivation (eligibility for free schools meals is used as an indicator of deprivation) shows that, across all ethnic groups, pupils eligible for free school meals (FSM) were less likely to achieve A* to C in GSCE English and Maths than those who are not eligible; 39% of FSM-eligible pupils attained top grades in these core subjects compared to 67% of those not eligible. Among Muslim ethnic groups, 44% of Pakistani boys and 51% of Pakistani girls eligible for FSM achieved A* to C grades in GSCE English and Maths compared to 58% and 65% respectively of non-FSM Pakistani boys and girls. Among Bangladeshi pupils, similar findings can be seen, with non-FSM pupils performing better than FSM-eligible pupils, and girls outstripping boys in attaining top grades: 62% of Bangladeshi boys and 60% of Bangladeshi girls eligible for FSM achieved A* to C grades in GSCE English and Maths, compared to 67% and 73% of non-FSM Bangladeshi boys and girls, respectively. Among Asian groups, Pakistani boys and girls performed the worst irrespective of FSM eligibility.[126]

Research compiled by Nabil Khattab and Tariq Modood of Bristol University has found a rising disparity in the number of degree-educated Muslim females compared to Muslim males. Noting the "cultural transformation" that is quietly underway in British Muslim communities, Khattab and Modood note that "among 21-24 year old Muslims, slightly more women than men, 25% to 22%, have degrees.[127] Khattab and Modood explain that negative stereotypes about Muslim women can play a role in driving their determination to succeed in education although other research suggests that the high aspirations felt by Muslim parents for their daughters, over their sons, can also play a role. Muslim parents have higher educational aspirations for their children than other parents and slightly higher for Muslim girls than for Muslim boys. More than two thirds (70%) of parents with a Muslim daughter said it was 'very likely' that she would go to university, while 64% said the same about their Muslim sons, compared to 43% for non-Muslim girls and 34% for non-Muslim boys.[128]

The research is significant when we take into consideration two relevant contexts, the value Muslims attach to education in terms of self-identity, and cultural norms which can affect the economic aspirations of educated Muslim females.

Survey research by Ipsos Mori concludes that education is important, with Muslims being much more likely than others to feel that their level of education is an important part of their self-identity.[129] The greater importance attached to education among Muslims may be construed as reflective of both their immigrant ancestry and of their desire for social mobility; where education serves as signifying 'status' in the host country and as currency through which to attain upward mobility.

But the impact of better education on social mobility is not uniformly felt, with the Social Mobility Commission noting "an explicit recognition that within some communities, women are encouraged to focus on marriage and motherhood rather than gain employment", despite having a graduate level education. Such cultural values about the role of women within the family and home were deemed to contribute to "limiting social mobility" of young Muslim women "if and when communities prioritise marriage and motherhood over a young woman's pursuit of a career." The Commission further highlights the effect of cultural norms and family expectations on the individual aspirations and the tension which can arise between the exercise of individual choice by Muslim females and the "narrow focus" on either family or career path by their families.[130]

124 Ethnicity Facts and Figures, available at: https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/11-to-16-years-old/percentage-achieving-a-c-in-english-and-maths/latest

125 Nabil Khattab and Tariq Modood (2018) Accounting for British Muslim's educational attainment: gender differences and the impact of expectations, British Journal of Sociology of Education, 39:2, 242-259

126 https://www.ethnicity-facts-figures.service.gov.uk/education-skills-and-training/11-to-16-years-old/percentage-achieving-a-c-in-english-and-maths/latest

127 University of Bristol, '"Cultural Transformation" as Muslim Girls out-Perform Boys Academically, Research Says', 4 April 2016. http://www.bristol.ac.uk/news/2016/april/muslim-women-degrees.html. The analysis uses data from the Longitudinal Study of Young People in England, with interviews carried out 2002-13.

128 Kully Kaur-Ballagan, Roger Mortimore and Glenn Gottfried, A review of survey research on Muslims in Britain. Ipsos Mori, 21 March 2018

129 ibid

130 Jacqueline Stevenson, Sean Demack, Bernie Stiell, Muna Abdi, Lisa Clarkson, Farhana Ghaffar and Shaima Hassan, The Social Mobility Challenges Faced by Young Muslims. Social Mobility Commission, September 2017.

However, no consideration of disadvantage or discrimination faced by Muslims would be complete without regard for the systemic effect of institutional racism which can manifest in unequal outcomes for Muslims irrespective of institutional processes and procedures which ostensibly champion equality and fairness. In her study examining British Muslims in higher education, Jacqueline Stevenson refers to the paradox of visibility/invisibility that pervades Muslim students' experience of higher education and which can result in "unequal outcomes" in respect of teaching experience, student life and class of degree obtained. Describing the paradox as one where social and ethnic diversity on campus is "celebrated" but religious diversity is "unrecognised and unacknowledged", Stevenson argues Muslims students can be made to feel "invisible, ignored, overlooked, undervalued or disregarded as Muslims." At the same time, "prevailing discourses around the threat faced from Islamic fundamentalism on campus", and universities as "sites of radicalisation" responsible for the implementation of the statutory duty to refer individuals suspected of exposing some vulnerability to radicalisation, can contribute to Muslims being made to feel "highly visible" on campus.[131] The visible/invisible paradox can have serious consequences for Muslim students affecting their "sense of belonging on campus which may, in turn, affect self-esteem, confidence, or integration, and thus has implications for retention and attainment, and for Muslim students' overall experiences of being a student in UK higher education."[132]

"Institutional Islamophobia" is frequently used to describe the institutional dynamics that produce and reproduce unequal outcomes for Muslims. Though the institutions may profess to abide by or champion laudable aims in respect of equality and fairness for all, there are at work "processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which [can] disadvantage minority ethnic people."[133]

Given the palpable effect prejudicial attitudes and behaviours can have on Muslims in sectors as wide-ranging as education, employment, healthcare, housing, higher education and on mental health and wellbeing, exploring the prevalence of such attitudes in society and how Muslims feel about how they are perceived is worthy of consideration.

## *Islamophobia and anti-Muslim attitudes*

In September 2017, NatCen with the Runnymede Trust published a report titled 'Racial Prejudice in Britain today'. The report found that 1 in 4 (26%) Britons admitted to being racially prejudiced, although the stated figure is wrapped in caution that the high improbability of individuals disclosing racist views to interviewers would suggest that the figure is likely to be higher still.[134] The report further examines specific strains of prejudice, with questions about how individuals would respond to members of other races or religions marrying into their family. The survey data shows that individuals display levels of hostility towards Muslims that are not seen when compared to other groups. In 2013, 50% and 46% said 'most White people in Britain' would 'mind' if a close relative married someone of Asian or Black background, respectively. Of those who would 'personally mind' if a close relative married someone who was Asian or Black, 21% of respondents said yes if the person was of Asian background, and 22% if the person was from a Black background. In contrast, "70% of respondents said that most White British people would mind if a close relative married a Muslim and 44% of respondents said they would mind themselves."[135]

131 Jacqueline Stevenson, "Muslims Students in UK Higher Education: Issues of Inequality and Inequity", Bridge Institute for Research and Policy, October 2018. http://bridgeinstitute.co.uk/wp-content/uploads/2018/10/Bridge-Higher-Education-report-2-FINAL.pdf
132 ibid
133 William Macpherson, The Stephen Lawrence Inquiry. Report of an Inquiry, (United Kingdom: The Stationary Office, 1999). Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/277111/4262.pdf p. 43.
134 Nancy Kelley, Omar Khan, Sarah Sharrock, "Racial prejudice in Britain today", NatCen Social Research, September 2017, p. 7. http://natcen.ac.uk/media/1488132/racial-prejudice-report_v4.pdf
135 ibid p.11

Other polling data which offers a useful insight into attitudes towards Islam and Muslims in Britain and perceived compatibility of Islam with the values of British society' is the YouGov GB tracker poll. With data available between January 2015 and February 2019, the tracker shows almost consistent results over the period in terms of those who say "There is a fundamental clash between Islam and the values of British society" and those who agree "Islam is generally compatible with the values of British society". There is minor variation in the figures over the four-year period with almost half of respondents (45%) almost consistently agreeing with the "clash" scenario, compared to a quarter of people (24%) who say that Islam and the values of British society are "generally compatible".[136]

As cited in the report by the Citizens UK Commission on Islam, Participation & Public Life, "More than half of Britons (56%) now regard Islam – the religion generally, as distinct from Islamic extremists – as a threat to the UK".[137] Other polls conducted in recent years affirm the public's sentiment that Islam is "a threat" with a Populus poll in 2016 revealing that over half of the British public (56%) agreed with the statement "Islam poses a serious threat to Western civilisation." [138]

The belief that Islam is "a threat to the UK", to the "values of British society" or to "Western civilisation", can serve to widen the gulf between an integrated identity and separated or marginalised identities, in Platt and Nandi's formulation, by "devaluing" that aspect of a Muslim's identity that is derived from belief in and observance of Islam as a religion. The 'master-signifier' role that Islam plays in an individual's identity can suffer when public perceptions deem the signifier a threat, or worse, an obstacle to be eradicated if integration is to be attained. The "heightened perception of inequalities in treatment and in life chances", referred to by Platt and Nandi as affecting the strength of British identity asserted by ethnic minorities is not just, therefore, a perception comprising material inequalities but can also extend to a perception in inequality of treatment when it comes to popular sentiments towards Islam and Muslims. Public attitudes that are distrustful of Islam and scathing of the ability of British Muslims to be both British and Muslim, can be just as harmful to the prospect of fostering an integrated identity - where contact participation with the majority group and cultural maintenance of minority group identity co-exist and benignly complement one another.

There is evidence that the public's view of Muslims is unfairly influenced by the actions of a few. A 2016 ComRes study found that more than four in five people (78%) believe that extremist views and actions conducted in the name of Islam by a minority of Muslims has an unfair impact on perceptions of all Muslims.[139] The preceding paragraphs have sought to highlight how the prevalence of negative attitudes or discriminatory behaviours towards Muslims affect their lived experience in the form of material disadvantage and institutional Islamophobia. It can further be seen in the direct experiences of prejudice and discrimination, as well as in fears of an increasingly hostile environment in Britain in which being a Muslim is becoming steadily more difficult.

The EHRC, in its ground-breaking report 'Developing a national barometer of prejudice and discrimination in Britain', found that 70% of Muslims said they had specifically experienced religion-based prejudice.[140] A review of survey data on Muslims by Ipsos Mori found three in five (63%) Muslims from minority ethnic groups think there is more prejudice against Muslims than against other religious groups. The perception is especially widespread among young Muslims and graduates, with one in four (27%) Muslims saying they have experienced discrimination but this rises to one in three (34%) for graduates and Muslims aged 18-24.[141] In a poll of Muslims conducted by ComRes for BBC Radio 4's Today programme in 2015, 46% of Muslims said that "prejudice against Islam makes it very difficult to be a Muslim in this country". Among younger Muslims, 18–34-year-olds, the figure was higher, at 48%.[142]

136 GB Tracker: Islam and British values. YouGov, available at:https://yougov.co.uk/topics/politics/articles-reports/2016/02/19/tracker-islam-and-british-values
137 Jack Sommers, "7/7 Bombings anniversary poll shows more than half of Britons see Muslims as a threat", Huffington Post, July 6, 2015
138 Populus, Hope Not Hate Survey, 4,015 GB adults aged 18+ years, interviewed 1-8 February 2016
139 ComRes, Islamic Caliphate Survey, 2,012 GB adults aged 18+ years, interviewed online 22-24 April 2016
140 Abrams, D., Swift, H., and D. Houston. 2018. Developing a national barometer of prejudice and discrimination in Britain. Equality and Human Rights Commission. p. 10.
141 Kully Kaur-Ballagan, Roger Mortimore and Glenn Gottfried, A review of survey research on Muslims in Britain. Ipsos Mori, 21 March 2018
142 BBC ComRes 2015

In an ICM poll conducted in 2015, two in five Muslims (40%) felt there is "more religious prejudice against Muslims than there was five years ago" and three in five (61%) felt there is more prejudice against Muslim people than against other religious groups. Perceptions of anti-Muslim prejudice was higher among younger, well-educated British Muslims with 71% of 18–24-year-olds and 79% of UK degree holders saying the same; just one in twenty Muslims (5%) felt they face less prejudice.[143] Similar results can be seen in a 2016 Populus study where over half the British public (57%) said they felt discrimination is a serious problem for Muslims in Britain, with many younger people, 18-24 year olds, believing this to be the case (75%).[144]

In 2010, a quarter of Muslims and a third of younger Muslims and graduates felt they had experienced discrimination in the UK in the past five years; 6% of men and 2% of women feel they have been discriminated against "often". Younger Muslims were more likely to say they had been discriminated against, 36% of 18-24 year olds compared to 17% of those aged 55+ years. Among those who had experienced discrimination and reported it, ethnicity, race or skin colour was given as the most likely reason for the bias, (70% of those reporting discriminations and 19% of the whole sample) with religious discrimination also cited as a likely factor (49% of those reporting and 13% of the whole sample, respectively).[145]

Similar patterns are seen in a different cohort study of 17-19 year olds in England. One in ten young Muslims (10%) when asked if they have ever been treated unfairly by teachers at school, said yes because of their religion, and 11%, a slightly higher number, said they felt teachers had treated them unfairly on account of their race, skin colour or ethnic background.[146] Clearly, race and religion are important and relevant factors in Muslim experiences of discrimination affecting Muslims differently based on sex and ethnicity. Female Muslims encounter high levels of Islamophobia in relation to dress where their 'visibly Muslim' status can expose them to a higher incidence of discrimination and hate crime; Black Muslims face significant racism as well as Islamophobia and so encounter an additional ethnic penalty.[147] As the survey data shows, such experiences are more likely to affect younger Muslims than older groups.

143 ICM Survey of Muslims for Channel 4: interviews with 1,081 Muslims aged 18+, conducted face-to-face across Great Britain on 25 April-31 May 2015, and with a nationally-representative control group of 1,008 adults aged 18+ by telephone on 5-7 June 2015.
144 Kully Kaur-Ballagan, Roger Mortimore and Glenn Gottfried, A review of survey research on Muslims in Britain. Ipsos Mori, 21 March 2018
145 Ethnic Minority British Election Study, 2010, 1,140 GB resident Muslims aged 18+
146 Longitudinal Study of Young People in England, first cohort (born 1989-90) wave 5 (interviews June-October 2008): 1,404 Muslim and 8,676 other subjects, interviews with young people and their parents
147 Stevenson et al, ibid

# Faith and cultural sensitivity in mental health services

The foregoing analysis drew on empirical and other data to illustrate the psychosocial, economic and environmental factors affecting the lives of young Muslims and shaping their views on identity, inclusion and belonging, perceptions or experiences of discrimination and outlooks on life as a young Briton, including friendship groups and volunteering habits.

The analysis presents a useful contextual framework when we examine recognised risk and protective factors which can influence and shape a young person's mental health. Resilience to events, whether these constitute minor or major changes to the circumstances in a young person's life, can be affected by the personal resources they have available to them to navigate shifts that can be unsettling or profound. By the same token, the absence or paucity of available resources can make it harder for a young person to 'weather the storm', leaving them more vulnerable and less buoyant in the face of challenges.

As part of this study, we were interested in the particular role of faith, both as a protective and risk factor, when it comes to the mental health of young British Muslims but before we turn to the survey and data analysis, a brief summary of some of the studies which have focused on the role of faith and spirituality in wellbeing and mental health follows.

An early project undertaken by Dr Sushrut Jadhav in 2002, 'Sensitising mental health to Islam', sought to develop guidelines for working with Muslim in-patients in a mental health setting by improving clinicians' knowledge of Islam and Muslims, and enhancing mental health professionals' understanding of experience of Muslim inpatients in a mental health setting to support culturally sensitive care provision.[148] The small-scale study illustrates some of the tangible benefits arising from closer scrutiny of two inter-related factors: clinicians' self-understanding of religion and its importance in the lives of patients, and patients' assessment of how well religion is integrated into the quality of care received. The study also highlights several notable caveats, including that knowledge alone is insufficient to improve quality of care - attitudes and behaviours when it comes to applying treatment is what matters, and also that no amount of self-knowledge should serve to substitute for a patient's request - that is, it is for the patient to determine how much and how far they wish their faith to be drawn into conversations about care and treatment.

A later study by Jadhav examined the role of Muslim chaplains in mental health settings, identifying various ways in which imams can provide support to clinicians and patients in mental health treatment. As with the above-cited study, person-centred approaches are essential, with a key question framing the integration of faith and spirituality in treatment being "What does being 'Muslim' mean to you?". A recommendation noted then which remains relevant still is that "It is crucial that hospital staff are made aware of — and be sensitive to — these issues in our increasingly multicultural, multi-faith society."[149]

A 2007 study supported by Rethink and drawing on a questionnaires and interviews with Pakistani Muslims living in Birmingham, sought to understand perceptions of mental health and illness within these communities, to explore their specific needs when it comes to mental health treatment, and to identify some of the reasons for the low uptake in mental health services. While stigma, shame and fear were principally the reasons individuals gave for stunted pathways to accessing services, suggestions for improving rates of uptake included cultural and faith sensitivity in service provision and better use of community resources (mosques, imams) when disseminating key health messages. Again, a key recommendation from the research focused on services meeting the needs of a diverse population: "Mental health services should introduce comprehensive staff training programmes to ensure that everyone working in mental health has appropriate values and skills to work with diverse client groups."[150]

148 Salas, S., et al. (2004) Sensitising Mental Health Professionals to Islam, in Shaw, T. and Sanders, K. (Eds) *Foundation of Nursing Studies Dissemination Series.* Vol.2. No. 5.
149 Sue Salas and Sushrut Jadhav. 2004. Meeting the needs of Muslim service users in *Professional Nurse* September 2004 Vol. 20 No. 1, pp 22-24.
150 *Our voice: the Pakistani community's view of mental health and mental health services in Birmingham,* report from the Aap Ki Awaaz project. Rethink, 2007.

As part of its 'Bridging Cultures, Dissolving Barriers' project, run by Mind in Harrow in partnership with the NHS, ways of "bridging the gap" between service providers and ethnic minority communities' expectations or experiences of mental health services identified both the importance of religion and faith for mental wellbeing and the need for better training in cultural and faith literacy, so that health professionals "take time to hear a patient's narrative" and "pay attention to others' beliefs in a non-judgmental way". And again, the use of faith-based organisations and religious leaders as an avenue for disseminating key messages about mental health and support services to and within Muslim communities was emphasised. [151]

Weatherhead and Daiches in their study into 'Muslim views on mental health and psychotherapy' examined conceptions of mental distress and how mental distress can best be addressed for Muslims as a heterogeneous group through qualitative analysis of interviews conducted with Muslim participants. The study highlights the confluence of religious and secular strategies and religious and non-religious rationales for health-seeking behaviours among Muslims, while noting the prevalence of religion in responses probing causes of mental distress, problem management (or coping strategies), relevance of services, therapy content and therapist characteristics. Some of the themes arising from this study are mirrored in our own survey findings, as we shall see later in the report. What is worth reiterating here is the relevance of faith and spirituality when it comes to addressing the specific needs of Muslim service users. As Weatherhead and Daiches note, "Therapy may be made more sensitive to Muslim clients by incorporating some of these themes of patience, and prayer into individual and group work."[152] Similarly, the use of community assets to open access pathways for Muslims is among the recommendations raised in the study with the use of mosques and community centres as locations for community service provision put forward.

The University of West Scotland and Oxfam, in partnership with the Amina Resource Centre in Glasgow, undertook a small-scale study involving Muslim women following an increase in the number of women approaching the centre with concerns relating to "jinn, spirit possession and black magic in connection with their health and, in particular, with their mental health."[153]

The study draws attention to subjects that evince areas of incongruence between the 'western medical model' and concepts or beliefs that are specific to religious or cultural contexts, thus creating gaps in mutual understanding when it comes to communicating mental health struggles faced by Muslim women that are related to jinn, spirit possession and black magic. While the percentage of respondents involved in the study who were likely to explain mental ill-health predominantly in terms of supernatural phenomena was small, the responses to questions probing low or late access to mental health services by Muslim women suggests the absence of faith and cultural sensitivity in service provision, the "unmet needs" of Muslim women, plays a significant role. Unsurprisingly, the study repeats the necessity of "cultural competencies" among health and social care professionals to cater for a wider range of persons experiencing mental ill-health and requiring blended approaches, medical and faith-based support, to treatment, specifically Muslim women.[154]

Hanif Bobat's user-led research on the benefits of attending the mosque among Muslim men with severe mental ill-health found that alongside the "place-based" advantages of the mosque; as a "community centre", a venue where individuals experience a "sense of peace", a space that allows them to cement a sense of belonging and identity among fellow Muslims with whom they share religious beliefs and a common worldview, there are also specific therapeutic benefits such as "prayer as therapy."[155] The research adds to literature that recognises the value of integrating community assets into access pathways as well as treatments when it comes to working with Muslim service users for whom mosques are a vital connection between the self, spirituality and a sense of belonging and community.

151 Natalie Tobert. 2010. *Bridging Cultures, Dissolving Barriers: End of Year Evaluation Report 2009 / 2010.* MIND Harrow.
152 Stephen Weatherhead and Anna Daiches. 2010. Muslim views on mental health and psychotherapy in *Psychology and Psychotherapy: Theory, Research and Practice,* 83: 75–89.
153 Darryl Gunson, Lawrence Nuttall, Smina Akhtar, Adam Khan, Gizala Avian and Linda Thomas. 2019. S*piritual beliefs and mental health: a study of Muslim women in Glasgow.* UWS-Oxfam Partnership: Collaborative Research Report No 4, University of the West of Scotland and Oxfam.
154 Ibid
155 Hanif Bobat 2001 *A User-Led Research Project into Mosque: Exploring the benefits that Muslim men with severe mental health problems find from attending Mosque.* The Mental Health Foundation.

The 'Guide to Healthy Living: Mosques' by Public Health England, in partnership with Birmingham City Council and KIKIT, is a prime example of collaboration between public health and statutory agencies and Muslim communities on how to utilise community assets to improve mental health literacy in Muslim communities and enhance wellbeing and general health.[156] The pamphlet, which highlights the role of mosques in the UK in developing "initiatives aimed to inform, educate and improve their environment, health, lives and wellbeing", identifies the general health problems besetting Muslim communities in Birmingham and highlights examples and suggestions of how mosques can utilise their physical settings and communicative advantages over a local population to address these problems. Examples range from tackling obesity through helping mosque congregations to make healthy food choices, to physical exercise facilitated by mosque-led walking groups and sports classes. The guide makes specific mention of mental wellbeing as an area of focus for mosques, with examples such as mental health first aid courses organised to train mosque volunteers to identify, understand and help a person who may be at risk of developing a mental health issue, and Friday sermons to challenge the stigma attached to mental health struggles in Muslim communities.

A significant empirical contribution to the integration of faith sensitivity in the treatment of mental ill-health can be found in the work of Mir et al. on Adapted Behavioural Activation.[157] The study, which tests the feasibility of a modified therapy for the treatment of depression by introducing interventions tailored to the needs of Muslim patients, shows how integrating faith sensitivity into extant effective methods can enhance benefits and outcomes for Muslim patients specifically.

Recognising the value of "religious coping techniques" when it comes to Muslim service users of mental health services, the Adapted Behavioural Activation (ABA) study aimed to develop the "positive religious coping" mechanisms available to Muslim patients for whom faith and spirituality are important aspects of their identity whilst avoiding the tendency to "negative religious coping", where feelings of guilt, shame or irreligiosity can have an adverse impact.[158] The enhancement to Behavioural Activation incorporating adaptations suitable for Muslim service users involved the creation of a manual for therapists to use when treating Muslim patients. While patient responses to the pilot were strongly positive, the views of therapists applying the method were more ambiguous, with important issues regarding self-reflexivity and discomfort with Islam as a value system emerging in the analysis. These factors can be discerned in our survey results too, with Muslim service users referencing some of the negative experiences they have encountered from mental health service providers and therapists. Given the divergence between reactions to the pilot from patients and therapists, Mir et al conclude that "Patients for whom religion is an important part of their core values should, we suggest, be supported by therapists who do not undermine this aspect of patients' identity, and can sincerely accept that religious values and behaviour can promote mental health." [159]

These studies show that faith and spirituality can have a positive impact on mental wellbeing and addressing mental health struggles. They also point to the assets in faith communities - such as religious leaders and places of worship - which can play a useful role both as a conduit for communicating to minority communities and as sites for service provision. This is not to suggest that the benefits are all positive or universal, indeed this and other literature clearly identify aspects where faith presents a problem or an obstacle to mental wellbeing and overcoming struggles. The purpose of summarising the ways in which faith and spirituality can be shown to play a positive role is to contextualise some of the findings from our survey.

156 Public Health England. 2017. *Guide to Healthy Living: Mosques.* PHE Publications.
157 Ghazala Mir, Shaista Meer, David Cottrell, Dean McMillan, Allan House and Jonathan W. Kanter. 2015. Adapted behavioural activation for the treatment of depression in Muslims in *Journal of Affective Disorders* 180(2015)190–199. 158 Pargament, Kenneth I., Harold G. Koenig, and Lisa M. Perez. 2000. The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology* 56: 519–43.
159 ibid

# Young Muslims and mental health

In the preceding section, a number of factors pertinent to the survey data analysis to follow were examined: identity and belonging, religion as an identity marker in the form of positive self-identification (chosen and affirmed by Muslims themselves) and negative stigma ('visibly' Muslim as attracting hostile conduct or attitudes towards Muslims), and types of disadvantage and discrimination faced by Muslims.

As research into factors influencing health inequalities for minority groups shows, apprehensions about acceptance among health professionals of religious identity and observance, socio-economic deprivation, perceptions of institutional racism and unexplained unequal outcomes can have debilitating effects. But what do young Muslims think about mental wellbeing, what kinds of mental health struggles do they/have they faced, and what help, if any, have they sought to deal with them, and from whom? Does faith have any role to play in these issues, whether normative (for example, how they conceptualise good mental health), or practical (for instance, turning to faith when confronting trials and tribulations)? The next section explores these questions in more detail by analysing survey data.

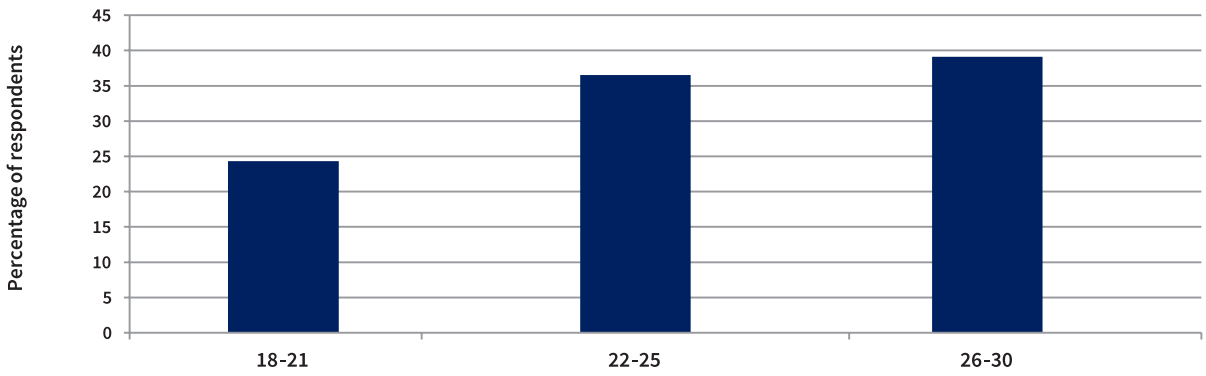
To begin, we present details of the survey sample. The methodology section sets out the manner in which the survey was distributed and a summary overview of the sample, but who is this survey about? The profile of the survey sample offers insights into some of the richness of the data compiled in this study, as well as some of its limitations. Given the variance within the sample in the categories of gender, ethnicity, geography and religiosity, this study has definite strengths but also certain weaknesses, for example, the sample is overwhelmingly South Asian, female, and London-centric.

Other features of the sample that are acutely relevant to the palpable strengths of the study are the number of participants who have (a) experienced mental health struggles (b) accessed mental health services. This study is about survivors and service users, and their experiences shared over the course of the survey add an incalculable value to the exploration of the mental health needs of young British Muslims.

### Age

The survey age group was 18-30, split across three ranges of 18-21, 22-25 and 26-30. Just under a quarter were in the younger category, with 24.3% of participants aged 18-21. Over a third were aged 22-25, 36.5%, and 39.1% were in the older category, 26-30.

Figure 5. Survey sample by age



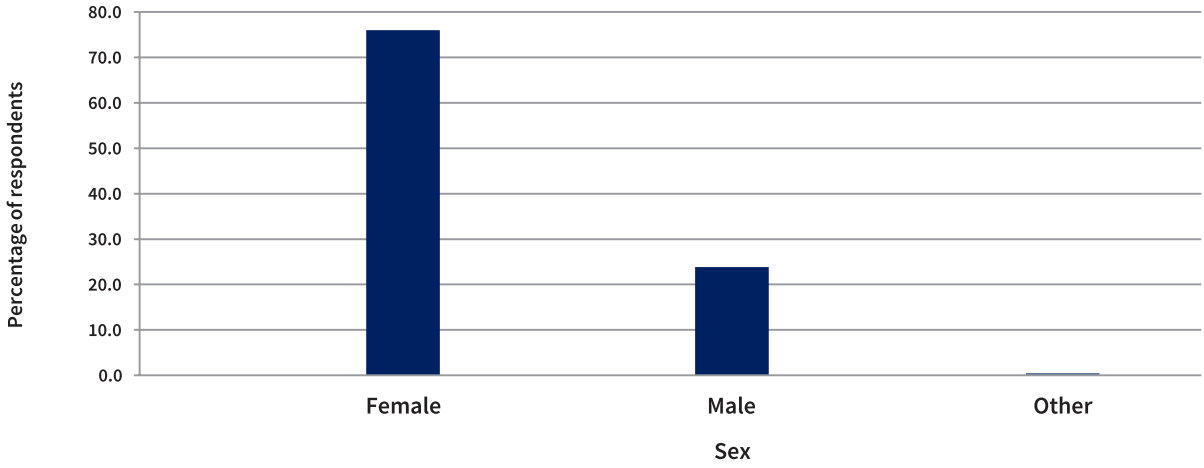
## Gender

The survey sample was predominantly female, 76% of participants, with under a quarter being male, 23.9% and 0.2% selecting other.

A gender bias is evident in the sample given the high proportion of participants who are female although, given the intensity of focus on Muslim females as subjects of inquiry in wider discourse and in the research literature, the preponderance of females may also be seen as an advantage, offering some insights into the ways in which media and political scrutiny of, for example, Muslim women's dress and Muslim women's agency, affects their mental health.

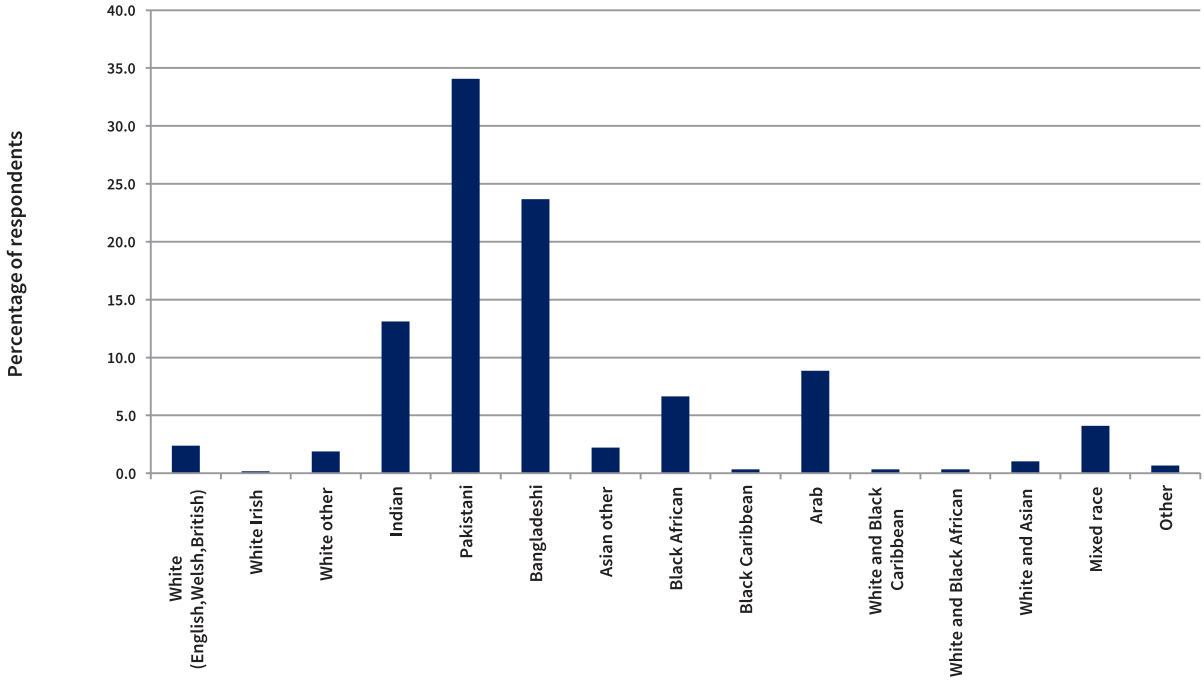
An obvious disadvantage is the comparatively low proportion of young men in the study and more research is needed to understand the mental health needs of young Muslim men than this analysis is able to provide.

Figure 6. Survey sample by gender




## Ethnicity

Figure 7. Survey sample by ethnicity

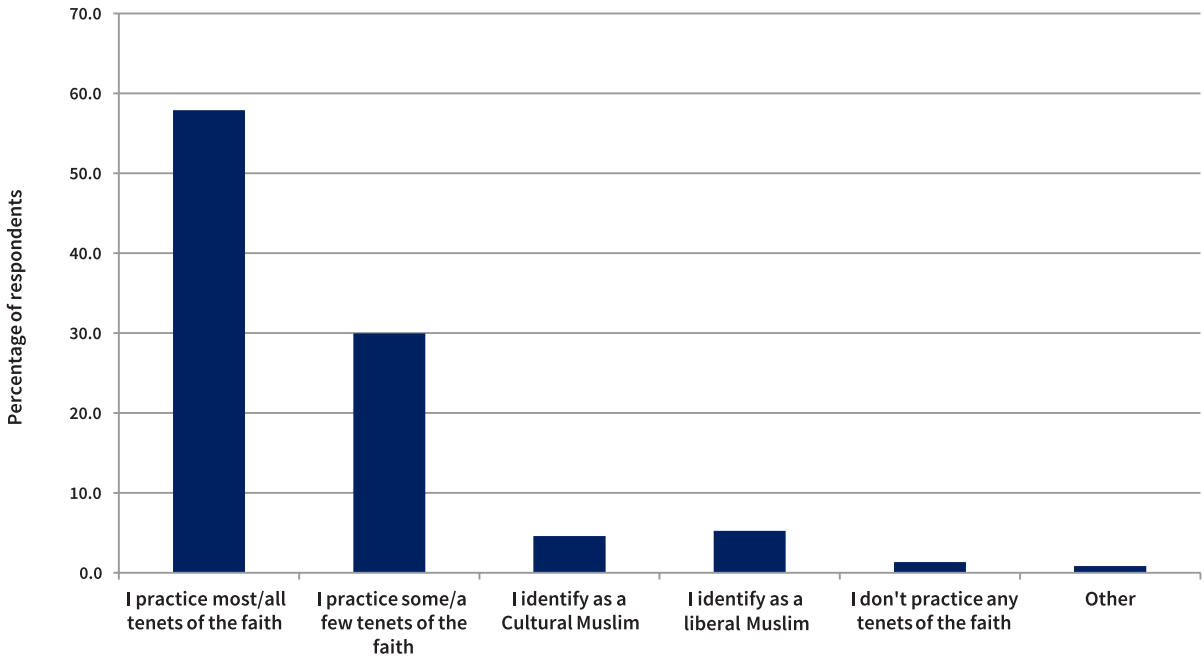


Indian, Pakistani and Bangladeshi, and Other Asian combined account for almost 75% of the sample. South Asians are clearly a dominant group in the survey sample. This may be a result of BCBN's reach into communities and the avenues used to distribute the survey. There is some representation of other ethnicities – White, Arab, Black African and Mixed race. Combined, these make up 24% of the sample. To provide some context to the survey sample, comparing to Muslims in the general population, it is worth bearing in mind that the proportion of south Asians within the British Muslim population, though still dominant, is declining. According to the 2011 census, 38.0% of British Muslims are Pakistanis, 14.9% are Bangladeshi and 7.3% are Indians. In 2001, just over a quarter (26.3%) of British Muslims were of non-Asian background but by 2011, this had risen to almost a third (32.4%).

What we can observe from the ethnic representation in the sample is that references to 'culture' have specific connotations, particularly in relation to South Asian culture. Secondly, we need more research to understand mental health struggles among young Muslims from other ethnic groups – e.g., Arabs, Somalis, Mixed race and white converts. These groups are not sufficiently represented in the sample.

### Religious practice

Figure 8. Survey sample by level of religious practice




More than half of those who answered the question attest to being religiously observant, and nearly 90% of participants are religiously observant to some degree. The profile makes the responses to questions on the role of faith when it comes to mental health particularly interesting. From the sample, service users are themselves quite religious and place a high value on religious literacy and culturally/faith sensitive services.[160]

160 Similar findings are to be found in older literature exploring mental health in ethnic and religious minority groups, see Modood, Tariq, et al. (1997). *Ethnic minorities in Britain: diversity and disadvantage.* No. 843. Policy Studies Institute and Cinnirella M, Loewenthal KM. (1999). Religious and ethnic group influences on beliefs about mental illness: a qualitative interview study. *British Journal of Medical Psychology.* 1999 Dec;72 ( Pt 4):505-24.

**'Visibly' Muslim**

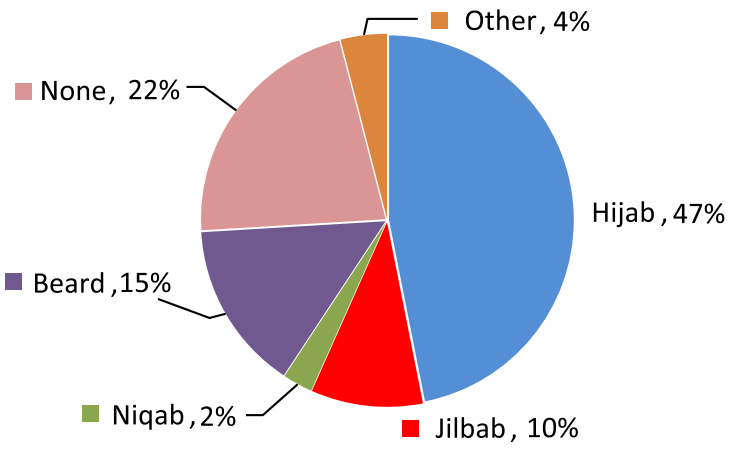
Participants were asked to describe any 'visible' symbols to their faith identity; that is, aspects of personal appearance that are specifically, such as hijab (headscarf) and niqab (face veil), or more readily, such as a beard, associated with Muslim identity. Over half the sample (58.7%) identified an item of clothing that they said made them look 'visibly Muslim'.

Just under a half of the women in the survey said they observed hijab, 47%, with 10% adopting the loose outer garment, jilbab, and a small number, 2%, observing the face veil, niqab. Of the 321 participants who wear the hijab, 64 also wore the jilbab, and 11 also wore the niqab. Among the women in the sample, the wearing of a headscarf was the most common form of 'visibly Muslim' appearance.

Among the men, 15% said they wore a beard. 22% bore no 'visibly Muslim' apparel and 4% noted Other. In the Other category, consisting of 27 responses, several of the written responses were of those who wore one of the optioned items of clothing, with the Other information provided additional detail on how they dress and the degree of 'visibility' to their Muslim identity. 5 of the females wrote "abaya". Though a jilbab or abaya connote the same item of clothing, a loose-fitting outer garment worn by some Muslim women, the choice of writing in this term in the Other category rather than selecting jilbab from the set options illustrates the diverse ethnic groups present in the sample and the use of varied terminology to refer to the same object. One female participant wrote "burka" alongside the selection of hijab and another female participant wrote that she wore "modest clothing" in addition to her hijab and jilbab. Modest clothing was also mentioned by two females who wear the hijab, and one female wrote she wore a "Part time hijaab". A further female offered the information that she wore a headscarf but "Started wearing recently but feel unsafe with it".

Among the men, four of those who mentioned they wore a beard also mentioned further items of clothing in the Other category: Hat, Kufi, Jubba and Thowb. A 'jubba' and 'thowb' are loose items of male clothing while the hat and kufi denote the skullcaps worn by some Muslim men. All items are strongly indicative of a Muslim identity.

Figure 9. 'Visibly' Muslim



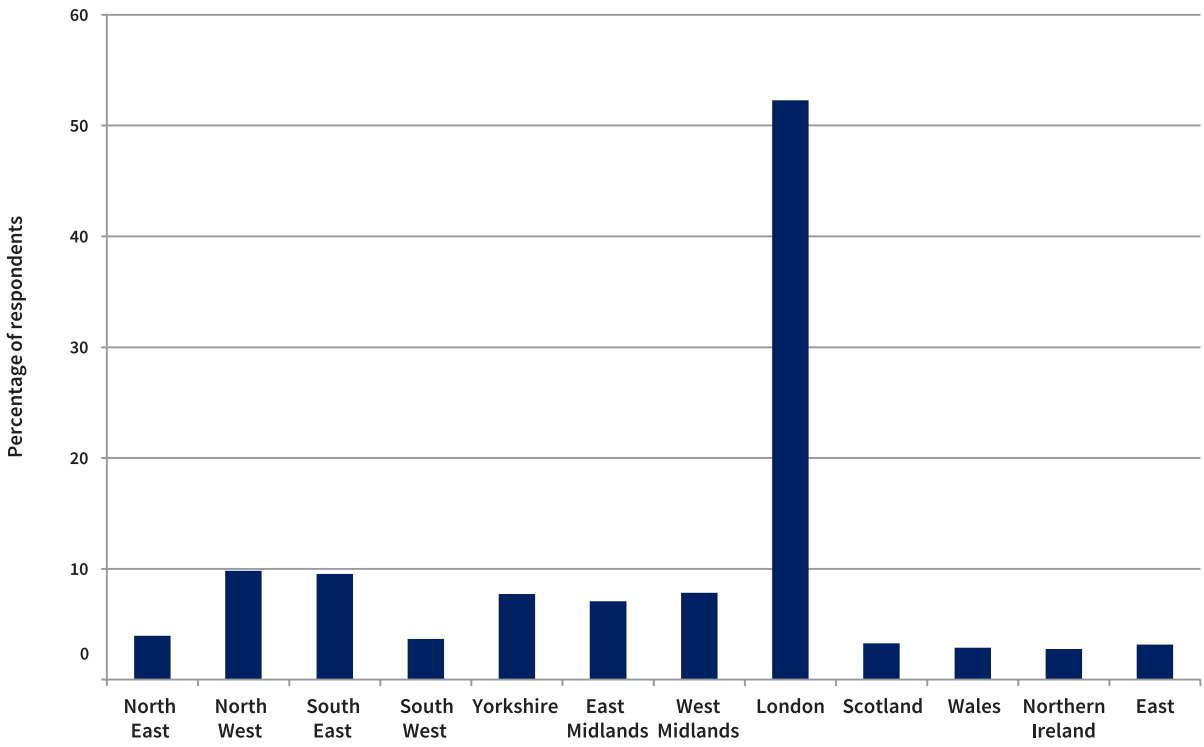

The remaining 12 responses were 8 female and 4 males. Of the eight women, three wrote modest clothing or "cover the body", while four described various states of wearing the hijab. Three wrote they wore the headscarf "part-time" or "sometimes", with one being a new wearer who was "inconsistent" in practice and another saying she wore it sometimes and "depends if I am travelling". A further participant wrote she sometimes wore the "turban", a different styled way of covering the hair. The remaining response was from a participant who previously wore the headscarf "until 9 months ago".

Of the four males, three referred to a "short beard" while the fourth, interestingly, referred to his "brown skin", insinuating the racialised identity that marks out Muslims in addition to any noticeable religious symbols.

## Geography

Geography is another area in which the sample shows an obvious bias with over half of participants, 53%, residing in the capital. This may be accounted for by the dissemination methods of the survey used by BCBN, the organisation is based in London. But given that the capital is also home to a diverse Muslim population, the London bias has also enabled the capture of an ethnically diverse Muslim population.

Figure 10. Survey sample by geographic region

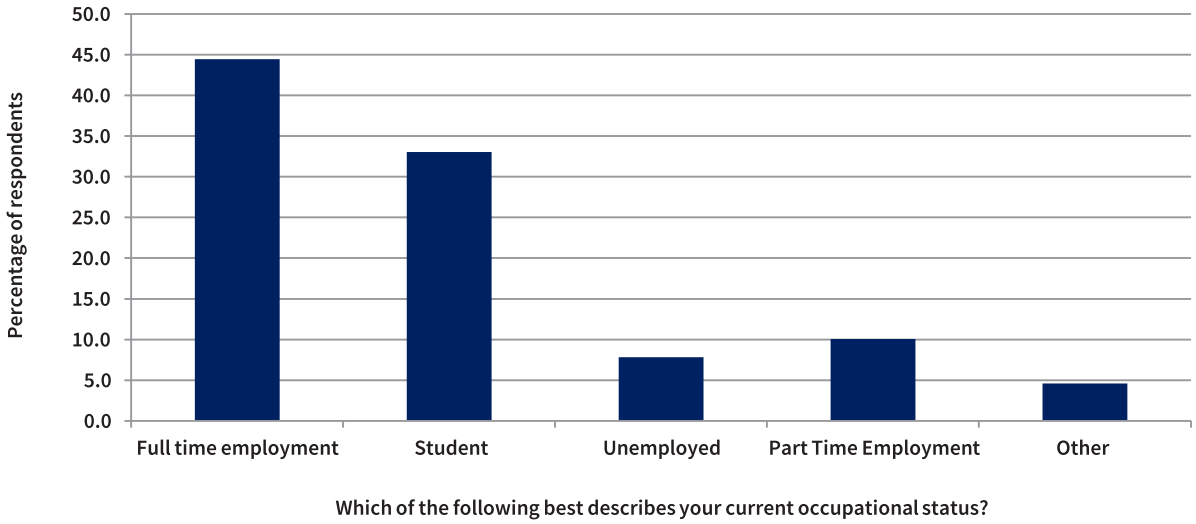



The second most prominent regions were the North West and South East, 10% and 9% respectively. The proportion from the South East is remarkable given the low density of Muslims living in the region. Yorkshire, the West Midlands and East Midlands make up 7%, 6% and 7% of the sample respectively, with the lowest number of participants living in the North East (2), the South West (2), Scotland (1), Wales (1), Northern Ireland (1) and the East of England (1). Two participants were not resident in the UK, one from Sri Lanka and another from Hyderabad, Pakistan. They have duly been omitted from the analysis.

### Occupational status

Around half the sample described their occupational status as full-time employment, 44.5%, with a 10.1% in part-time employment, and a third, 33%, being students. Unemployed status accounted for 7.8% of the sample. Those in the Other category were homemakers (8), on maternity leave (2), self-employed (5) or students who were also working in either part-time or full-time jobs (6). One participant was a freelancer, another a student looking for work, one was a pre-registration pharmacist thus not classed as a student status, and one participant noted they were "recovering from illness".

Figure 11. Survey sample by occupational status




There are two notable observations related to the occupational status of the survey sample that we would point out here. The first concerns workplace environments and the focus on making workplaces more inclusive of racial and religious diversity. The independent review by Baroness Macgregor-Smith made the economic case for diversity and inclusion, arguing the full utilisation of ethnic minority talent in the workplace would give the economy a £24 billion boost.[161] To this, we can add more recent research which argues that workplaces are a "safe bet" for the promotion of integration and cohesion strategies, with workplace diversity a key factor in bringing people of diverse backgrounds together. The Woolf Institute study, How We Get Along: The Diversity Study of England and Wales 2020, found three quarters of all workers in England and Wales work in a setting that is ethnically diverse, with over three quarters of all workers who self-described as religious saying they work in settings that are religiously diverse. Muslim workers were more likely than those of other minority religions to say they are "workplace solos", people who are the only representative of their ethnic, national or religious group at work. 1 in 8 Muslim workers are "workplace solos" compared to around 1 in 5 from the other minority faith groups (Hindus, Jews and Sikhs).[162] While the report identifies "workplace solos" as potential "ambassadors" for their minority group in the workplace, being "well-placed to challenge stereotypes and establish new norms of social mixing",[163] it is worth also noting that being the sole representative of a minority religious group in the workplace can place undue burdens on individuals. With mental health in the workplace an area of growing importance, these studies bear some relevance to workplace strategies on diversity and inclusion and their impact on the mental wellbeing of employees of ethnic minority background. The second observation concerns diversity in the student population at higher education institutions. It is difficult to assess changes in religious diversity on campuses given the optional nature of data recording prior to the 2017/18 academic year, when mandatory recording of religion or belief was required of institutions by the Higher Education Statistics Authority (HESA). According to the data for the 2018/19 academic year, Muslim students were the second largest faith group at UK universities behind Christians, who comprised the largest group, 8.4% and 24.7%, respectively.

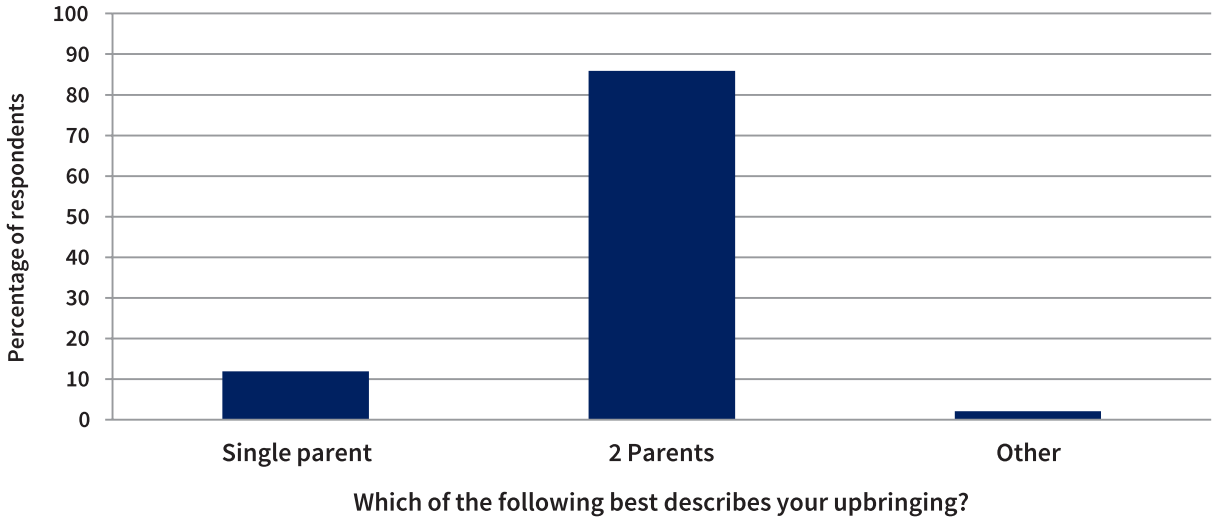
161 Race in the workplace: The McGregor-Smith review, February 2017.
162 Hargreaves, J. How We Get Along: The Diversity Study of England and Wales 2020. Cambridge: Woolf Institute, 2020).
163 ibid

Just under half of students reported having no religion, 45.1%. Comparing data on students' self-declared religious identity for the two years for which figures are available, there was an increase in the number of Muslim students, from 7.9% to 8.4%, and a minor increase in the number of students who reported having no religion, from 44.2% to 45.1%. All other religion or belief group figures stayed relatively similar over the two years.[164] With the number of Muslim students in higher education increasing, how institutions accommodate religion or belief on campus and in particular, in the mental health support services available to students is an area that should not be overlooked. In respect of both workplaces and universities, this report provides helpful insights into the mental health struggles faced by young British Muslims.

**Family background**

Participants were asked about their family background and their upbringing. The majority of participants grew up in two parent families, with 85.9% saying this arrangement described their upbringing. Single parent families made up 11.9% of the sample's family background.

Figure 12. Survey sample by upbringing



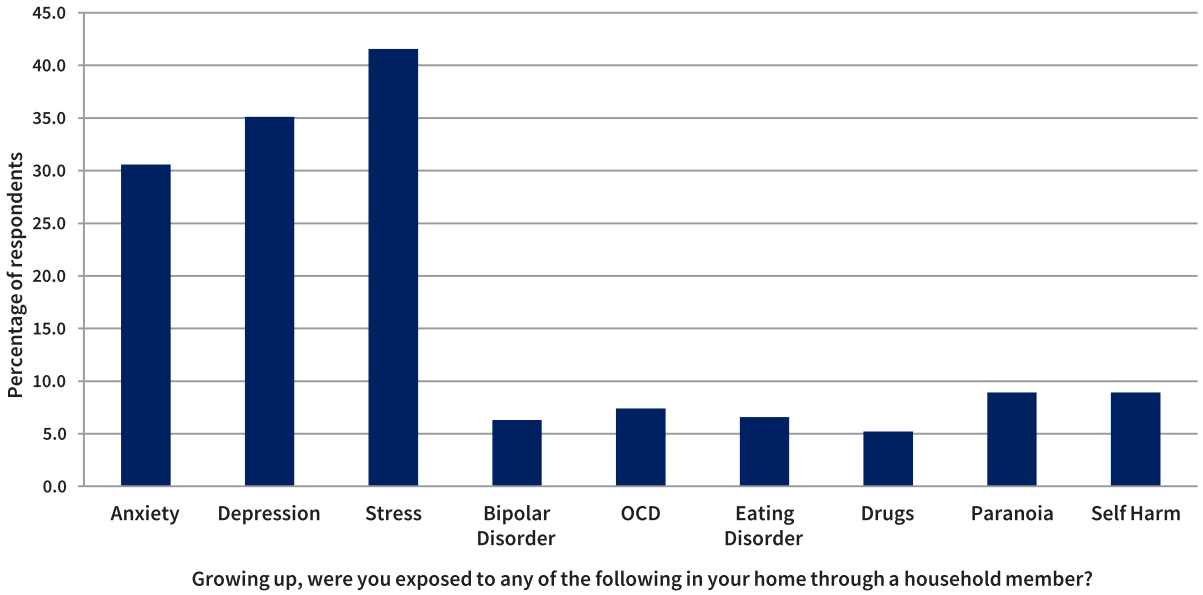

Of those who selected 'other' , the death of a parent during childhood explained the single parent upbringing with three participants noting the loss of a father before the age of 12.

Other participants described family backgrounds as either starting out as dual parent before becoming single parent, or the other way around, with a single parent upbringing turning into a two-parent background at a later time in childhood when the second parent re-joined the family. The ambiguity of a two-parent household was noted, with a participant stating that while both parents were married, one worked overseas. Divorce leading to a single parent upbringing or a step-parent arrangement was negligible in the sample, as was the parenting by extended family, with only four participants noting an upbringing led by grandparents or close relative (aunt/uncle).

Participants were also asked whether they had been exposed to various mental health conditions or behaviours through a household member. The most common condition participants were likely to have been exposed to was stress (41.6%), followed by depression (35.1) and anxiety (30.6). Other serious conditions participants noted were paranoia (8.9), self-harm (8.9), OCD (7.4), drugs (5.2), eating disorder (6.6) and bipolar disorder (6.3).

164 Advance HE, "Equality and Higher Education - Student Statistical Report 2020," Advance HE, October 22, 2020, https://www.advance-he.ac.uk/knowledge-hub/equality-higher-education-statistical-report-2020. p.248.

Figure 13. Exposure to mental health illness through household member



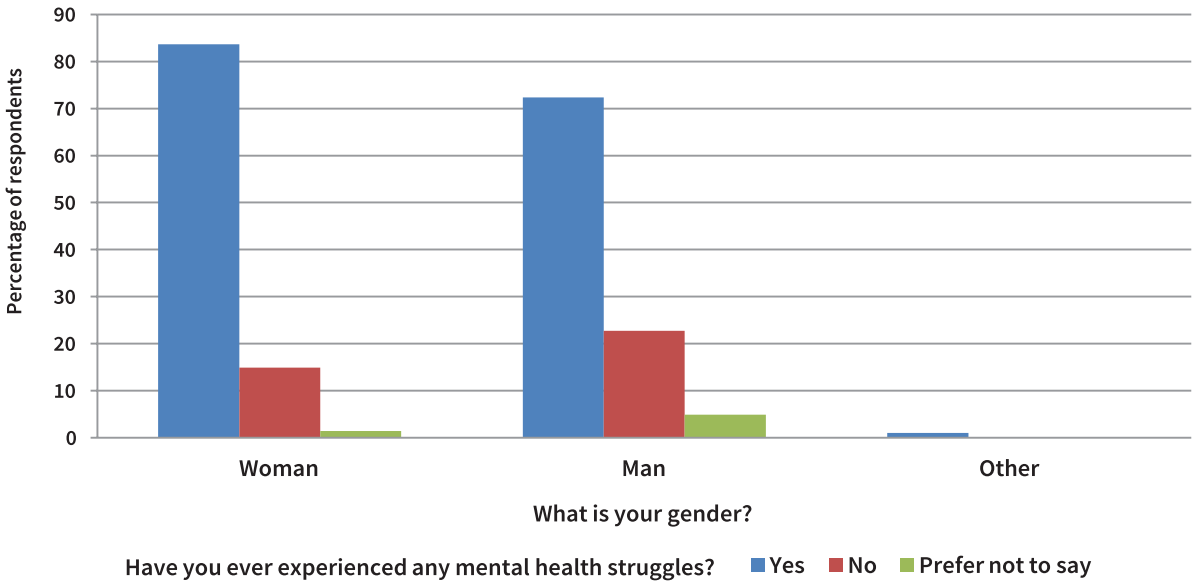

Participants were further asked whether any member of their family had been a victim of abuse within the home. Around half said no, (49.8%) and less than half said yes (45.3) with 4.9% selecting 'prefer not to say'. The most common form of abuse was physical with a quarter of participants, 25.1, saying this was the type of abuse experienced, while just under a quarter said the abuse was verbal, 24.6%. Financial abuse was mentioned by around one in ten participants (10.3) and sexual abuse by around one in twelve (8.6). In all types of abuse, the predominant perpetrator of the abuse was an immediate family member. More than a quarter of respondents, 27.3%, said the perpetrator was an immediate family member, with extended family member the second most common response, 13.6%.

# Experience of mental health struggles

Participants were asked whether they had ever experienced mental health struggles, and asked to describe the types of struggles they had suffered. Four in five participants said they had suffered mental health struggles, a staggering proportion of the sample (81.8%) stated that yes they had experienced mental health struggles, 16.7% said no, and 2.2% (12 participants) preferred not to say.

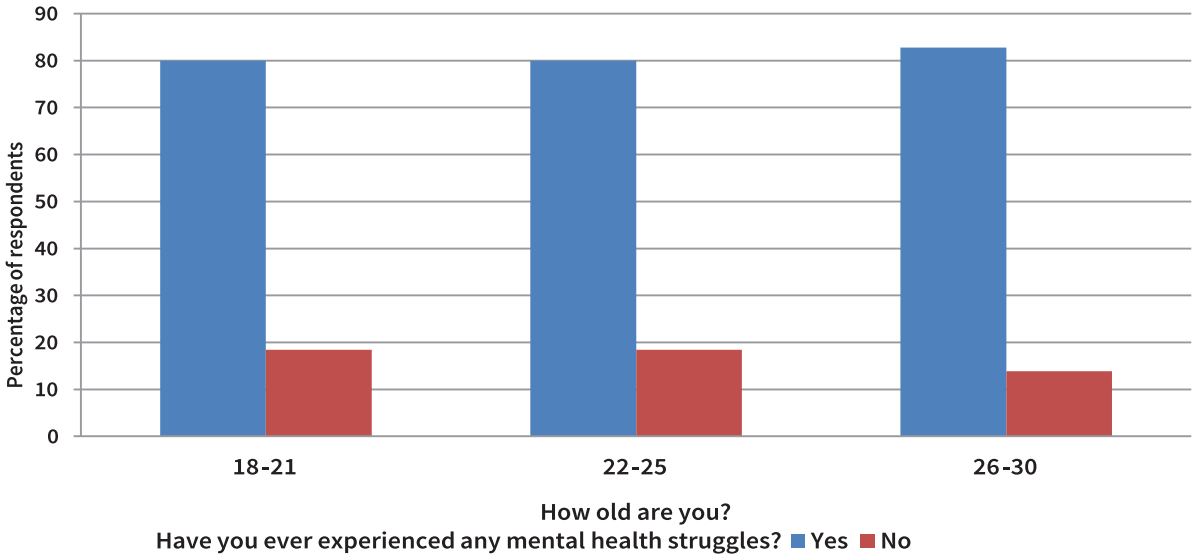
Women were more likely to say they had experienced mental health struggles than men, with 84% of female respondents saying they had experienced mental health struggles compared to 72% of male respondents who said the same.

Figure 14. Experience of mental health struggles by gender



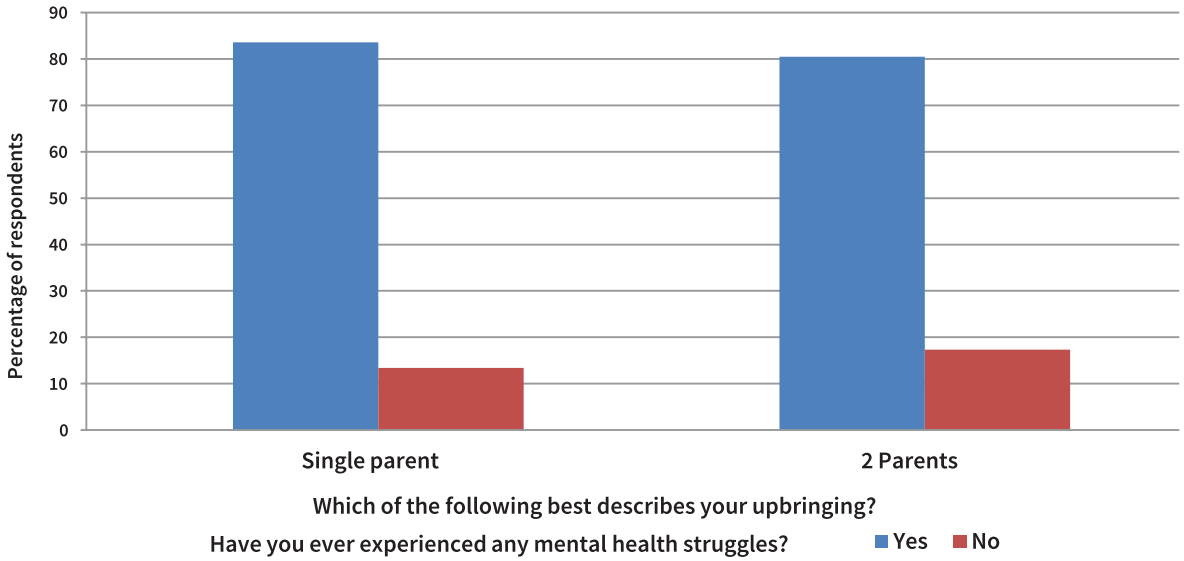

By age, those in the older age group were marginally more likely to report experiencing mental health struggles, 83%, compared to the younger two age groups, 22-25 and 18-21, both ay 80%.

Figure 15. Experience of mental health struggles by age



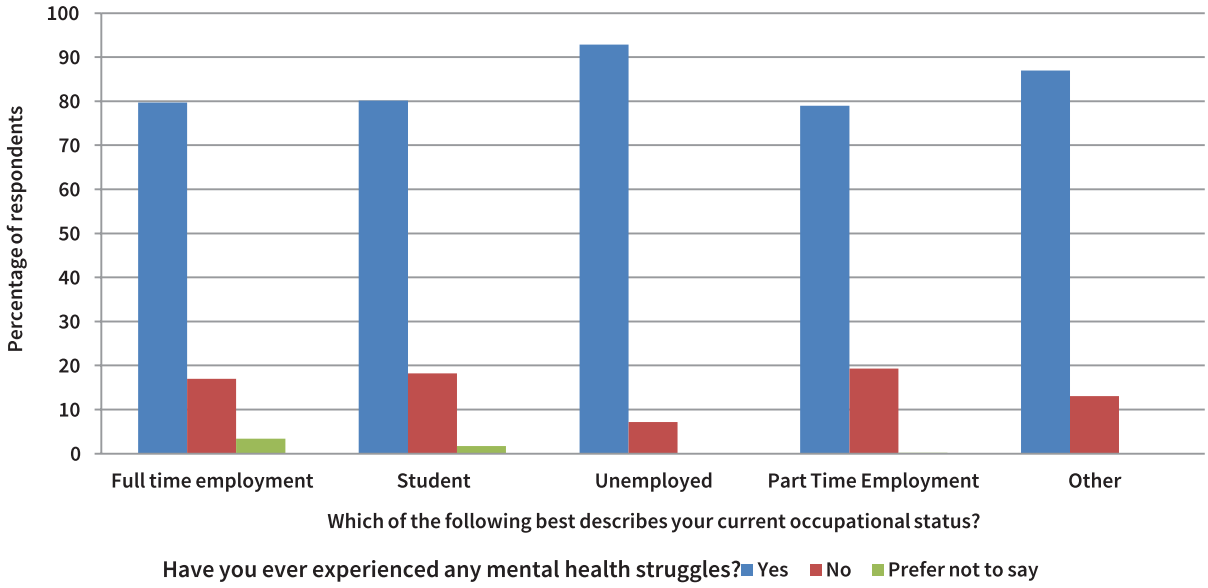
By upbringing, slightly more participants raised by a single parent said they had experienced mental health struggles, 84%, compared to 80% of those raised in two parent families.

Figure 16. Experience of mental health struggles by upbringing




As might be expected, those who were unemployed were more likely than those in employment, whether full-time or part-time, to say they had experienced mental health struggles but across all occupational states, the prevalence of mental health struggles was evident whether employees, students, or those in the other category (home-makers, self-employed etc.). The findings show that mental health struggles affect young Muslims in all sorts of occupational states, with those who are unemployed more likely to be vulnerable. The findings also show that workplaces and universities have an important role to play when it comes to addressing the mental health challenges faced by young Muslims who are in employment or studying.

Figure 17. Experience of mental health struggles by occupational status




Cross-tabulation of occupational status and types of mental health struggles shows those in full time employment were more likely than all others to experience every condition appearing in the drop-down menu, bar bipolar disorder which was more common among students. Experiences of abuse disorders, alcohol and drugs, were among the highest reported by those in full time employment, as well as OCD and common disorders, anxiety, depression and stress. Whether workplaces exacerbate these illnesses and, more pertinently, the role of workplaces in supporting employees to recognise, speak about and get help for these conditions, is a subject that deserves more attention.

Figure 18: Occupational status and mental health struggles by type

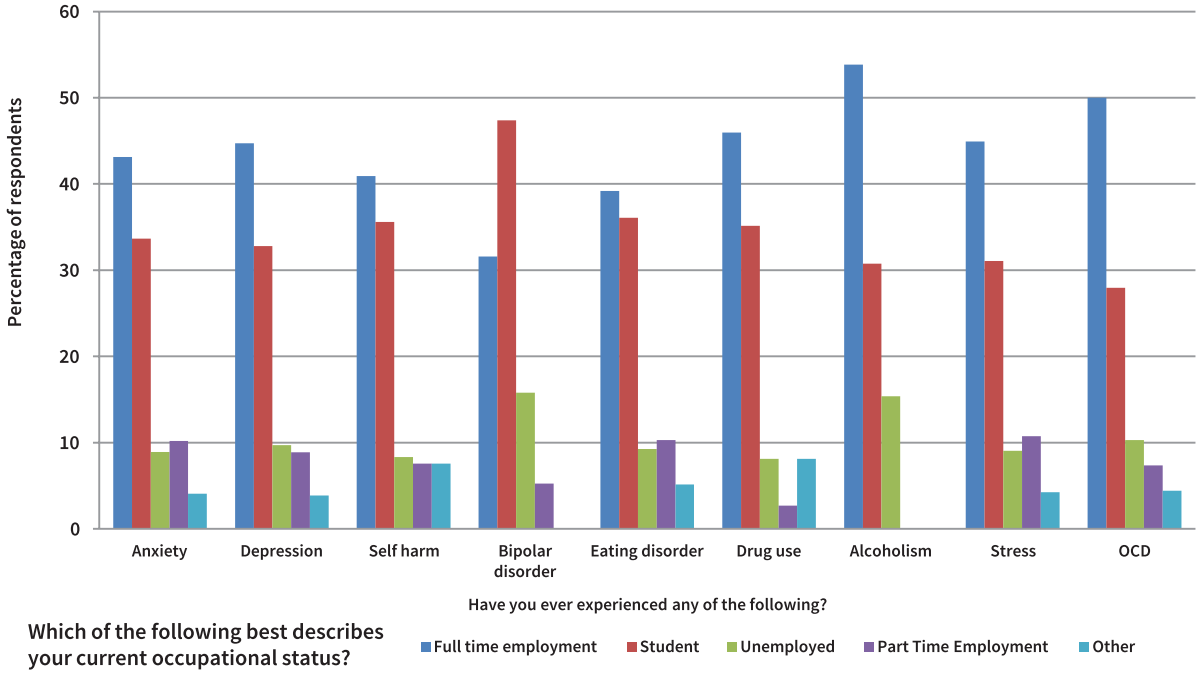
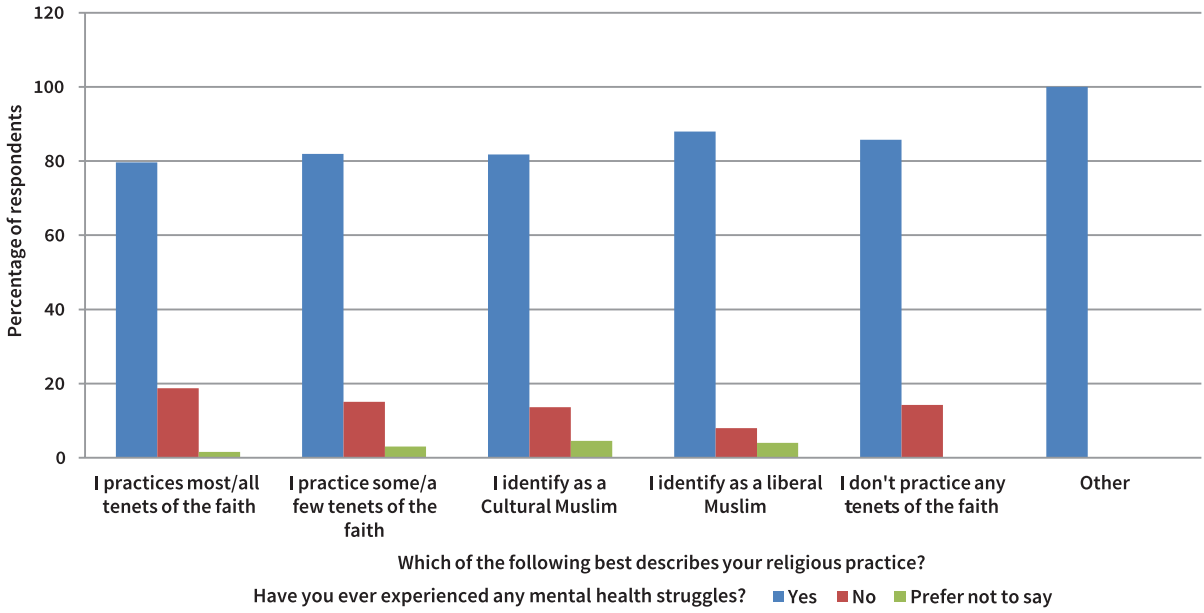


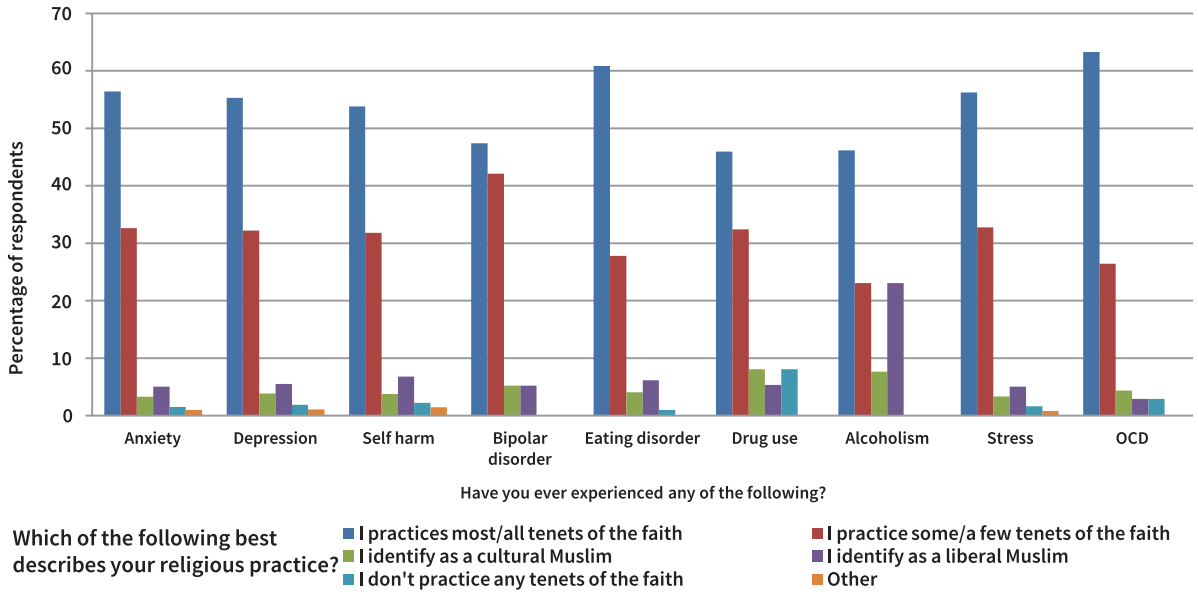

Figure 19: Level of religious practice and mental health struggles




Exploring mental health struggles by participants' religiosity reveals minor variation in the experiences between those who are keenly observant of Islam and those who self-describe as cultural or liberal Muslims. The percentages for cultural and liberal Muslims and other are somewhat misleading given the low number of participants in the survey who identified as such (22, 25 and 5 respectively). But the findings reinforce aforementioned arguments that mental health struggles are not confined to those who no longer practice the religion in which they were nurtured and raised.

It is not uncommon to hear claims about mental health difficulties not affecting those who are faithful in their religious observance. Indeed, in responses to later questions, as we shall see, participants refer to the rehearsing of these arguments when attempting to speak about their mental health struggles within Muslim communities. A common refrain is to presuppose mental health cannot be concern for those who are religious. The findings of this survey suggest such claims are not only wishful and irresponsible, but potentially dangerous.

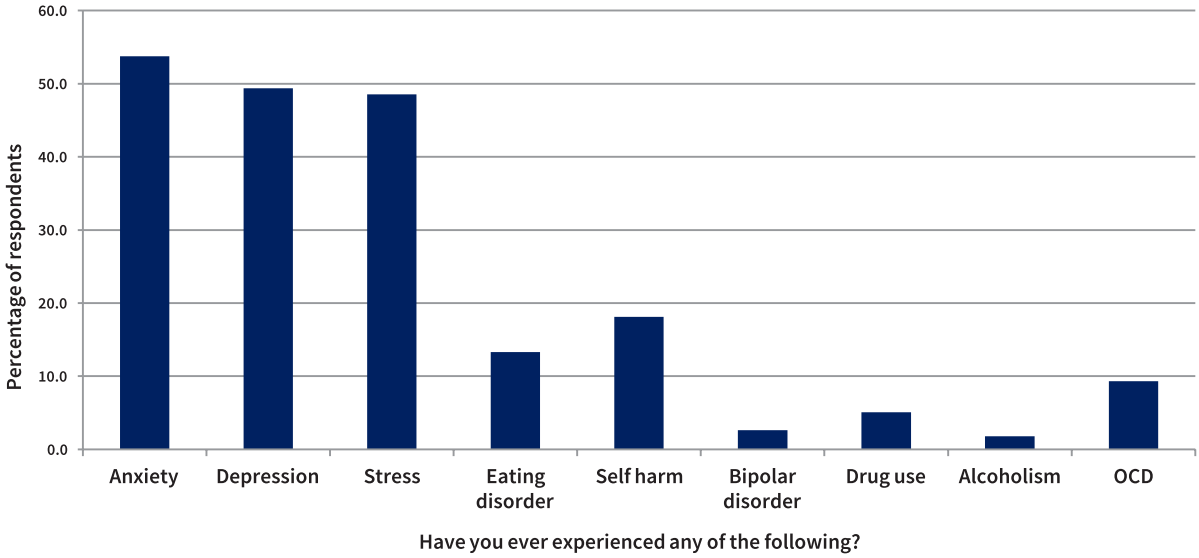
Figure 20: Level of religious practice and mental health struggles by type




Nor do we find the type of mental health struggles experienced inapplicable to those who say they practice most or all of the tenets of their faith. What is striking in the results is the huge number of respondents that are largely or to some degree religious observant who say they have experienced abuse disorders, alcohol and drugs, as well as the common mental disorders, anxiety, depression and stress. Assumptions about abuse not affecting 'good young Muslims', those who practice their faith, is not a healthy approach. What the survey findings show is these problems can affect anyone, whether religious or not. More importantly, given the level of religious observance disclosed by participants, it is germane that spaces within religious domains - mosques, community settings and within Muslim families - are available to them to access support and help from inside the milieu to which they are accustomed. If young people who are religiously observant cannot find opportunities to speak about their mental health struggles within religious domains, the possibility that these are first port of call narrows, a prospect that would be detrimental to young people and to the pastoral support structures within communities that are designed to nurture and support them.

Participants were given a list of conditions ranging from common mental disorders (stress, anxiety and depression) to more serious illnesses (OCD, eating disorder, bipolar disorder and self-harm). Health conditions which can exacerbate or contribute to mental health conditions were also given among the options, with drug use and alcoholism named in the survey.

Figure 21: Mental health struggles faced by type



The responses shown in the graph above illustrate the most mental health struggles faced by young Muslims with anxiety (53.8%), depression (49.4%) and stress (48.6%) the most commonly named struggles. Self-harm, eating disorder and OCD were other named conditions, with alcoholism, drug use and bipolar disorder affecting far fewer participants. The lesser showing of alcoholism and drug use could be linked to the religiosity of the participants, with both substances forbidden in Islam.

Mental health struggles showed interesting variances when examined by age groups. Young Muslims aged 26-30 were more likely to report experienced all types of struggles in greater proportion than the two younger cohorts, except in relation to alcoholism. A higher proportion of the younger age group mentioned bipolar disorder than in comparison to the other two groups, though in all other types of struggles the 18-21 year olds showed lower levels of experience.

The data also showed significant variations when assessed by gender, with females showing high levels across all mental health conditions, bar alcoholism and drug use. Given the gender bias in the sample itself, the difference can be explained in part by the high number of females who participated in the survey. Nevertheless, two findings which are worth taking note of are firstly, the scale of mental health struggles experienced by young Muslim women and secondly, more research is needed to better understand the mental health struggles faced by young Muslim males.

Figure 22: Mental health struggles by type and age

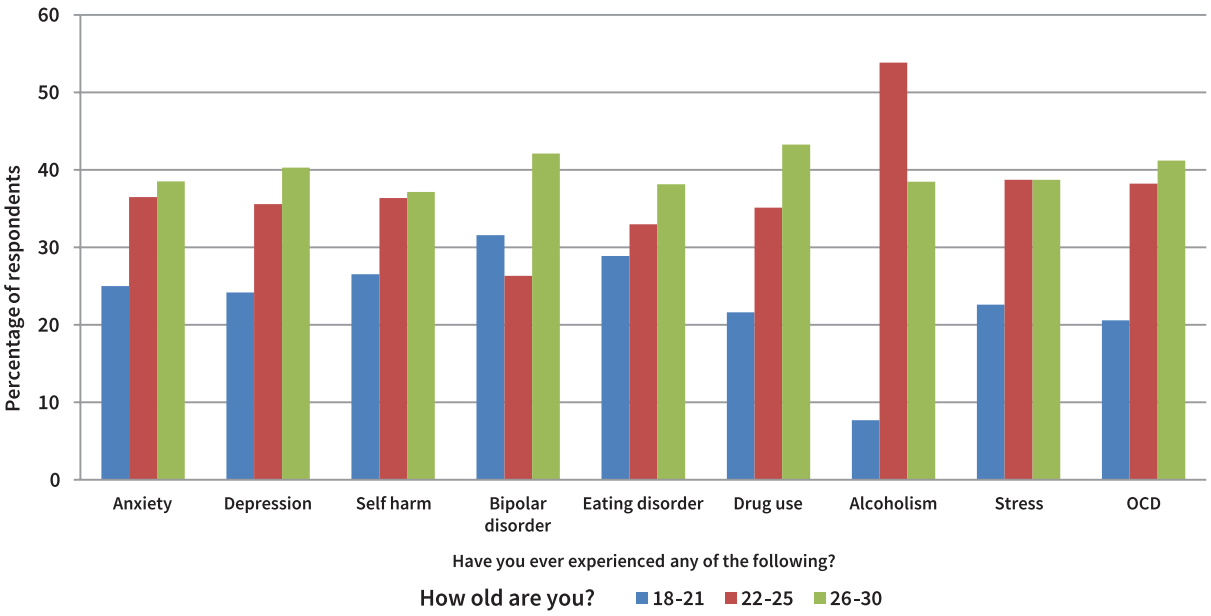
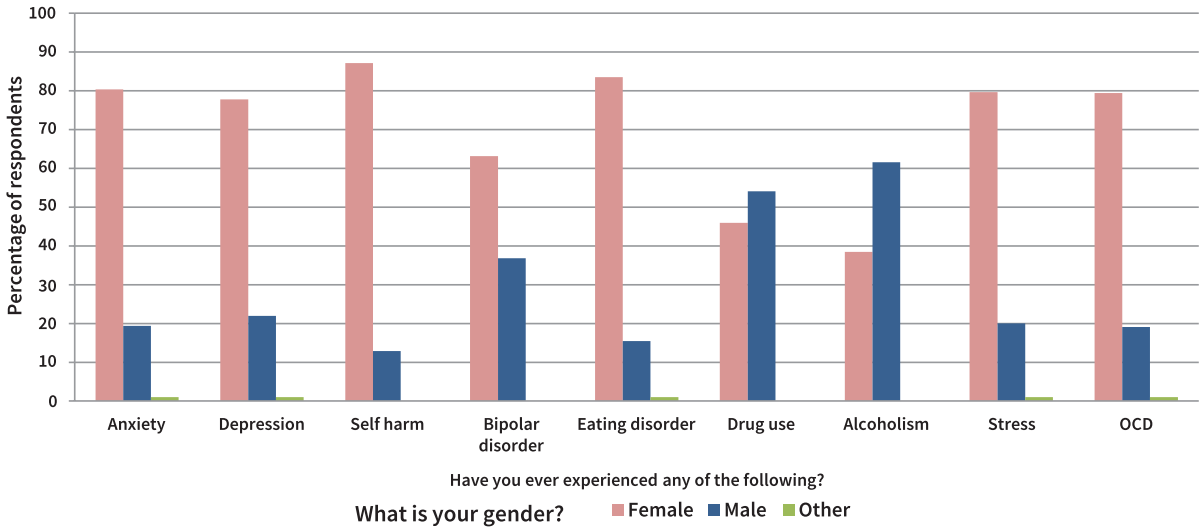
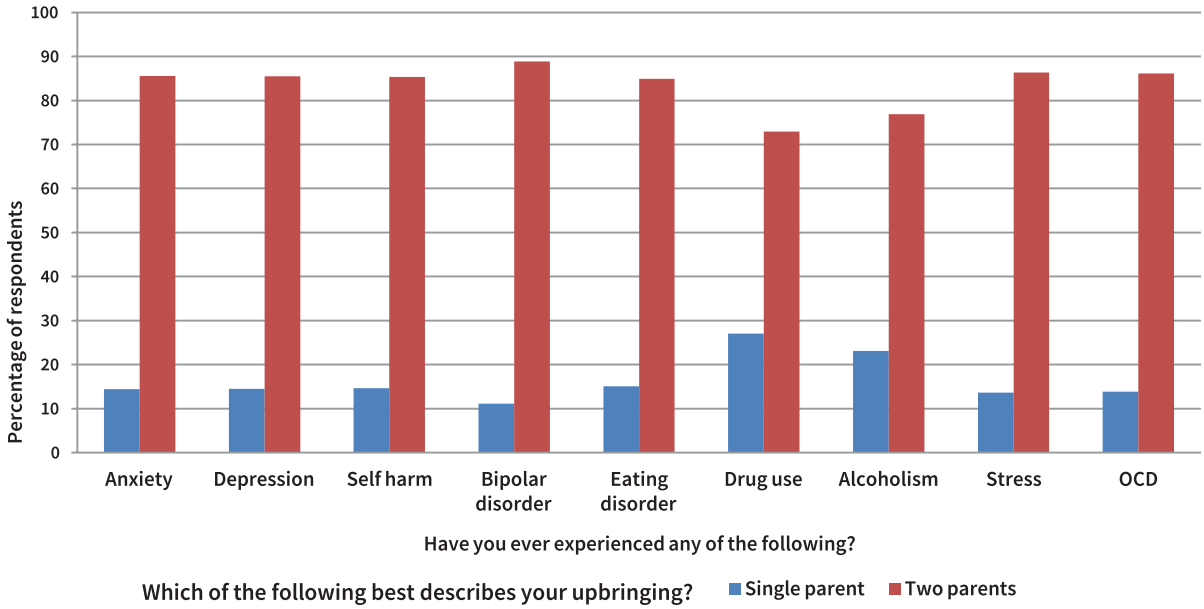



Figure 23: Mental health struggles by type and gender



A common misconception that mental health struggles emerge in broken families, or where young people do not have regular or steady contact with both parents, is not borne out in our sample. When looking at the experience of mental health struggles and a young person's upbringing, the vast majority of the participants reported being raised in two-parent families, but the frequency of mental health struggles over those reported by young people raised in single-parent households was consistent across all types.

Figure 24: Mental health struggles by type and upbringing




The findings provide an important insight into the difficulties faced by young Muslims, and gives rise to concern of a problem of "hidden survivors", of young people who are not seen or heard when it comes to acknowledging and recognising the struggles that they face.

# ‘Trigger’ factors

While the analysis draws no firm correlation between ‘trigger’ factors in a young person’s story and experiences of mental health challenges, cross tabulation is possible between different variables based on the responses to questions. Participants were asked to answer yes or no to questions about experiencing bullying, Islamophobia or abuse. The responses are presented below in more detail.

### Experiences of bullying

More than two thirds of participants reported experiencing bullying, 68.9% compared to 31.1% who said no. At what age bullying occurred shows schooling years as particular significant, with 273 participants saying it occurred between ages 12-16, 189 saying it happened between ages 7-11 and 82 experiencing bullying at the upper end of school years, 16-18. Early years were also notable in the sample, with 58 respondents saying they experienced bullying between the age of 0-7. While experiences as young adults were also evident, with 18-22 and 22-30 also reporting bullying episodes, 54 and 31 respondents respectively.

When it comes to where the bullying was experienced, the vast majority said it occurred in a public setting (public space), 73.1%, with school being the second most common answer, 46%. 10.2% said the bullying had occurred at home, 4.3% said it happened in a mosque, and online bullying was experienced by 7.4%. The numbers reporting bullying at school is significant when we consider the recollection entailed with answering questions as an adult about harmful events occurring in childhood, although, as mentioned above, a small proportion of those who experienced bullying did so as adults.

With regards to frequency, just under a third said the bullying occurred ‘many times’ (30.4%) with two in five saying it happened ‘a few times’ (41.5%). Those who experienced bullying once were 6% and 22.2% said frequency was not applicable.

### Experiences of Islamophobia

Just over two thirds of participants reported experiencing Islamophobia, 67.4%, compared to 32.6% who said they had not. Verbal abuse and name calling was the most common experience of Islamophobia followed by discrimination and physical abuse. Women were more likely to report all forms of Islamophobia, physical, verbal and discrimination, compared to men. The greater number of women in the sample accounts for some of the disparity, there not being equal numbers of women and men to allow for clear comparison, but the figures reported by the women still provide evidence of the gendered Islamophobia and the growing concern of the easy vulnerability to women to Islamophobic attacks due to their greater visibility and being seen as ‘easy targets’.

Those in the older age cohort were more likely to say they had experienced Islamophobia, with 18-21 year olds the least likely to say so. Cross tabulation with whether participants who experienced Islamophobia also experienced mental health struggles shows 70% of those who experienced mental health struggles had experienced Islamophobia. The survey did not examine a correlation between the two but research shows victims of hate crime are more likely to report being affected by the attack than those who are victims of regular crime. Being targeted on the basis of a specific bias, including religion, can impact on a victim’s wellbeing and recovery after the crime.[165]

Figure 25: Islamophobia and age

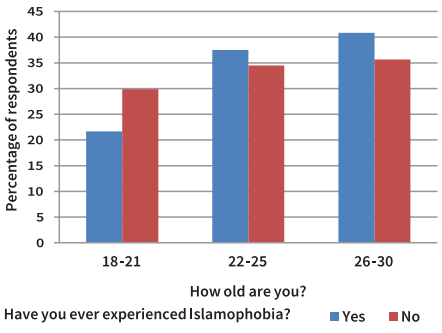
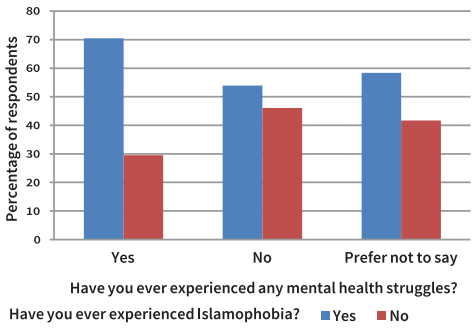



Figure 26: Islamophobia and mental health struggles




165 Corcoran, H., Lader, D. and K. Smith. (2015). Hate Crime, England and Wales, 2014/15 Statistical Bulletin 05/15. Office for National Statistics.

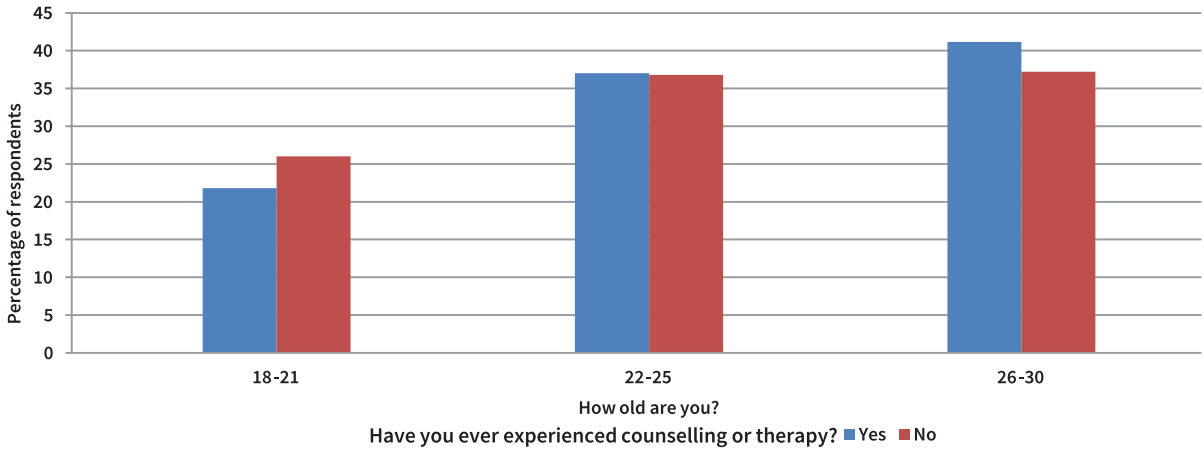
# Counselling and therapy

Among the most interesting details about the sample is the number of participants who have experienced counselling or therapy for their mental health struggles. The insights provided into experience of mental health services and stated preferences for services that are culturally/faith sensitive is of remarkable importance to the general interest in the subject matter and, more significantly, to the particular interest of BCBN to utilise the survey findings to encourage better service provision in partnership with the Muslim charity sector and Muslim mental health professionals. The findings bear strong import to the stated aim of the survey when it was first considered and offers knowledge and understanding that is not otherwise readily available.

The number of participants who have experienced counselling or therapy was almost evenly split. Around a third of participants did not offer an answer (32.4%). From the two thirds who did offer an answer (67.6) 49% said yes and 51% said no. Women were more likely to have experienced counselling or therapy compared to men, 84% of the women  has experienced it while only 16% of the men said they had.

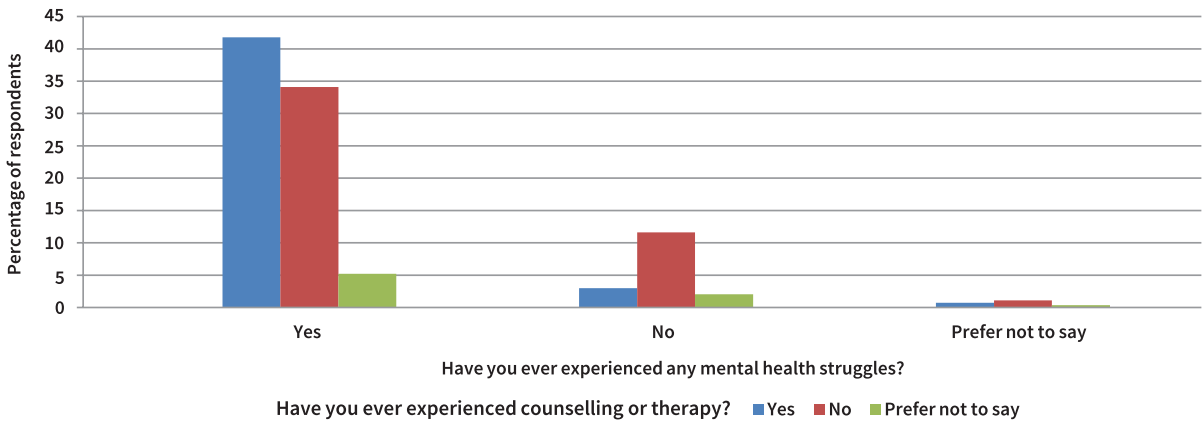
By age, the older cohort were more likely to say they had experienced counselling or therapy compared to the two other age groups with those in the 18-21 age category the least of those who had done so.

Figure 27: Experience of counselling by age



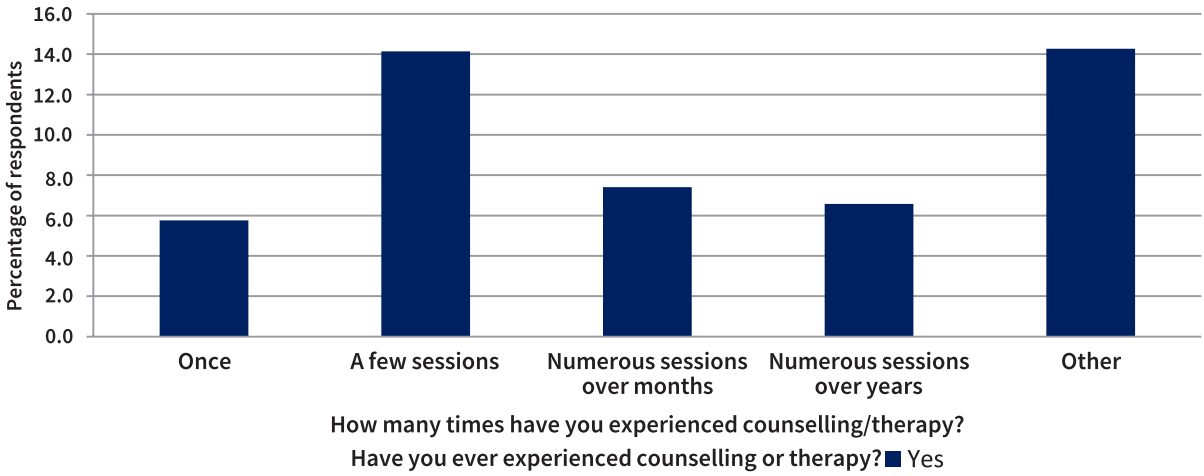

Looking at the numbers of those who have experienced mental health struggles who have engaged in counselling or therapy shows those experiencing difficulties have accessed some support, 42%. The cross-tabulation also shows that more than a third who have experienced problems have sought no help through counselling or therapy, 34%. There is a clear number of participants who have not received support and a smaller number who have but not for mental health issues.

Figure 28: Mental health struggles and experience of counselling



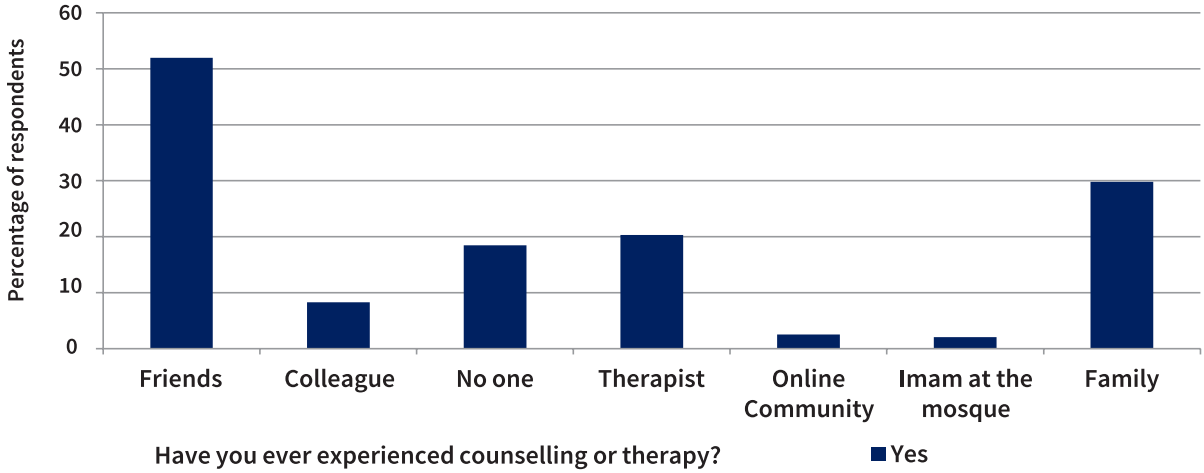
The number of times participants said they had experienced counselling or therapy shows a contrast between those who have been in frequent use of services and those who have experienced counselling or therapy only once.

Figure 29: Experience of counselling by frequency




Of those who said they have experienced mental health struggles, when asked whom they turned to the last time they experienced a mental health struggle, the majority of participants said they have turned to friends, 52%, followed by family, 30%. 20% said they had turned to a therapist, and almost equal number, 18%, said they had turned to no one. Far fewer participants said they had turned to an imam at the mosque, 2%, which is much less than the number who said they turned to a colleague, 8%.

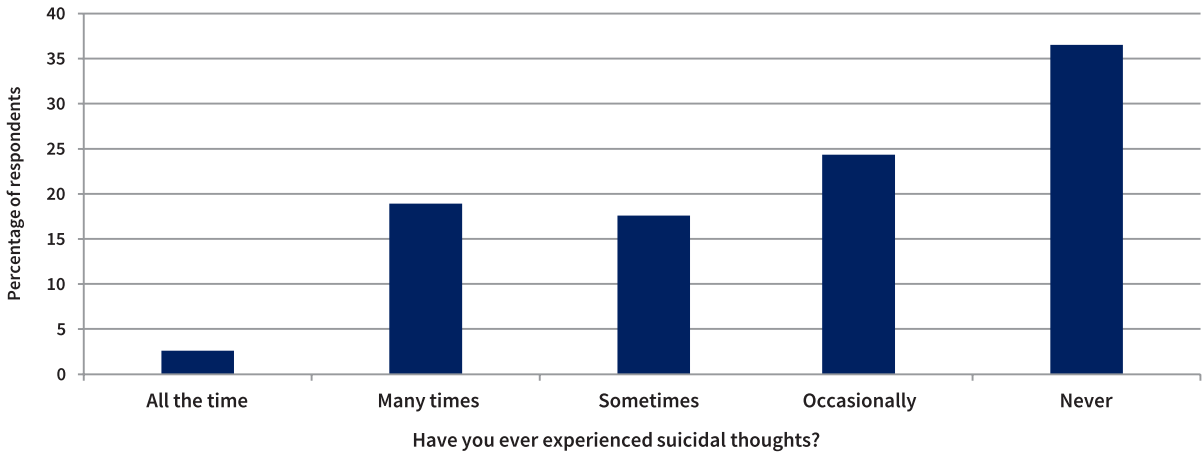
Figure 30: To whom did you turn the last time you experienced a mental health struggle?




The reliance of young Muslims on a network of friends is striking, and at times necessary given the reticence young people may show in turning to family to seek help and support, or knowing where else they might turn. But the reliance on friends also raises questions about the quality of help young people may receive. It also raises concerns about the exacerbation of a problem if proper support is not provided early on. What the information does indicate is the importance of widespread awareness of mental health struggles within families and Muslim communities, such that wherever young people might turn, to friends, colleagues, family or elsewhere, they are signposted to reliable support services that can offer them a safe space to talk about their struggles.

This point is rendered all the more important when we look at the figures on participants who said they had experienced suicidal thoughts. While the greatest proportion, 37%, were those who said they had never experienced suicidal thoughts, almost two thirds of those who answered the question said they had, ranging from all the time (3%), many times (19%), sometimes (18% ) and about a quarter who said occasionally, 24%. These are alarming statistics.

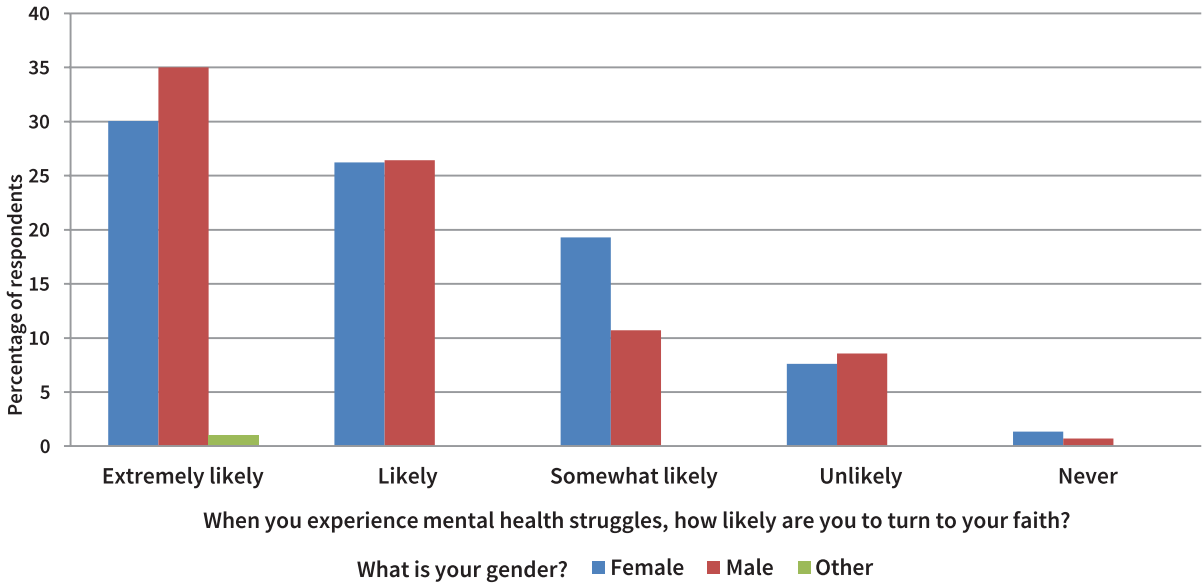
Figure 31: Suicidal thoughts by frequency




Coupled with the information on where young people turned the last time they experienced a mental health struggle, we must understand that, without offering helpful guidance on where and when to turn to others for help, and why speaking up about their struggles is a fundamental first step, we run the risk of leaving young people adrift with terrible consequences.

This is all the more poignant when we consider what young people say about the role their faith plays in supporting them when experiencing mental health struggles.

Figure 32: Turning to faith and gender




Both females and males said that they were extremely likely or likely to turn to their faith when they experience mental health struggles, with males saying this in greater numbers than females: 35% of young Muslim males said extremely likely, compared to 30% of females, while equal numbers said likely, 26%. More females than males said somewhat likely (19%), compared to 11% of young males, and more males than females said unlikely, 9% compared to 8%. The least common response was those who said they would never turn to their faith, less than 1% among males and females.

Young people evidently rely on their faith to support them through mental health struggles. To some extent, in a sample of this type which has a large proportion of those who observe most/all or some of the tenets of their faith, this might be expected. But by the same token, the inclination of those who are religiously observant who turn to faith when experiencing mental health difficulties demonstrates the relevance of faith as a factor when treating those for whom religious faith and ritual practice is an important facet of their lives.

# What is mental wellbeing?

The last twenty years or so have seen significant growth in interest in the subject of wellbeing. It is now a decade since the British government took concerted steps to measure the nation's wellbeing with the establishment in 2010 of the Measuring Wellbeing Programme (MWP) and the publication of key data on life satisfaction, how worthwhile people find the things they have done in life, and self-reported levels of happiness and anxiety by the Office for National Statistics. Whether informed by public health perspectives, health economics or public policy, wellbeing is a subject that is now firmly placed on the public health and public policy agenda.

Though there has been considerable development in indices to measure wellbeing in national and global contexts, with Linton et al noting a demonstrative rise in the number of wellbeing instruments developed in the decade 1990 and 1999,[166] the concept itself has no agreed definition and no single set of universally approved metrics to measure wellbeing.

The World Health Organisation incorporates wellbeing into its definition of health, stating it is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[167] The definition lends some weight to the capability approach proposed by Sen which goes beyond a simple assessment of subjective happiness, to measure wellbeing using frameworks that examine both individual aspirations and resources. As Sen notes, wellbeing is to be understood as the "real opportunities to do and be what [individuals] have reason to value".[168] The "functionings" of the individual, what they value and how they choose to pursue it in the form of activity, should be related to the "real opportunities" available to each individual by way of resources. That is, individuals should enjoy the freedom to choose from a range of "functioning" options, when value and resources are combined. The WHO's emphasis on potential and its realisation, through recognition that wellbeing is not to be understood merely as the absence of disease or infirmity, accommodates both the possibilities of variance in what individuals may value, and the resources available to attain a desired state, the "realisation" of these values.

The New Economics Foundation in the report, National Accounts of Well-being: bringing real wealth onto the balance sheet, which preceded the launch of the MWP, defined wellbeing as "the dynamic process that gives people a sense of how their lives are going, through the interaction between their circumstances, activities and psychological resources or 'mental capital'."[169]

In the Foresight report on Mental Capital and Wellbeing: Making the most of ourselves in the 21st century, to which the NEF contributed a model of wellbeing and its drivers, the concept was further refined to take into account the network of social relationships which can contribute to individual wellbeing. Wellbeing was defined as "a dynamic state, in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others, and contribute to their community."[170] A helpful guide to maintaining positive wellbeing, drawing on the NEF's wellbeing model, captured five key components, the first and last of which involve social interactions: Connect (social relationships), be active (physical activity), take notice (reflection, pause, mindfulness), keep learning (acquiring knowledge, personal growth and development) and give (volunteering, empathy, giving back).

166 Linton M-J, Dieppe P, Medina-Lara A. Review of 99 self-report measures for assessing wellbeing in adults: exploring dimensions of well-being and developments over time. BMJ Open 2016
167 World Health Organization. (1946). Constitution of the World Health Organization. http://www.searo.who.int/ EN/Section898/ Section1441.htm
168 Sen, A. 1993. "Capability and Well-being", in Nussbaum and Sen (eds.), The Quality of Life, Oxford: Clarendon Press, pp. 30–53
169 Juliet Michaelson, Saamah Abdallah, Nicola Steuer, Sam Thompson and Nic Marks. 2009. National Accounts of Well-being: bringing real wealth onto the balance sheet. New Economics Foundation. p3.
170 Foresight Mental Capital and Wellbeing Project (2008). Final Project report: 'Mental capital and wellbeing: making the most of ourselves in the 21st century'. The Government Office for Science, London.

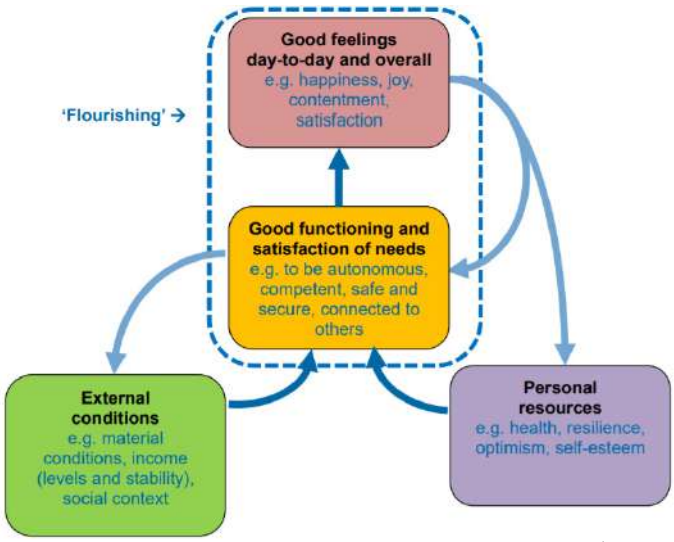
In a later piece of work by the NEF in 2012, wellbeing was broken down into three categories: how people feel, how they function, both on a personal and a social level, and how they evaluate their lives as a whole.[171]

How people feel refers largely to emotional states, whether individuals feel happy or content (positive emotions), or whether they suffer from feeling low or depressed (negative emotions). How people function refers to a "sense of competence" and a "sense of being connected" to people around you, while evaluation assesses life satisfaction and life quality, whether individuals find value and meaning to their life.[172] These metrics encompassing emotion (hedonic), life satisfaction (evaluation) and appraisals of value and meaning (eudemonic) are captured in the subjective wellbeing questions posed by the ONS, the so-called ONS4:

1. Overall, how satisfied are you with your life nowadays?
2. Overall, to what extent do you feel the things you do in your life are worthwhile?
3. Overall, how happy did you feel yesterday?
4. Overall, how anxious did you feel yesterday?

Subjective wellbeing factors are to be distinguished from the "potential drivers of wellbeing", both external (objective measures), such as income, housing, education and social networks, and internal (subjective), such as state of health, confidence and optimism, which have the capacity to influence how individuals function and consequently, what emotional states they attain; happiness or anxiety.[173] The image below illustrates the NEF's dynamic model of wellbeing[174] and signifies the causal relationships between wellbeing and the potential drivers of wellbeing where external conditions and internal resources interact to influence how well an individual is able to function thereby affecting the individual's emotional state; how they feel.

Figure 33:




(Source: New Economics Foundation)[175]

What the dynamic model shows is that where personal resources and external conditions combine to support good functioning, this will result in positive emotions which in turn compound the personal resources and external conditions to continue yielding good functioning and positive emotions. The individual attaining this outcome is described as being in a state of "flourishing" or thriving. Though the illustration does not refer to it, the inverse also holds where personal resources and external conditions can combine to drive poor functioning, resulting in negative emotions and the cycle perpetuating with feelings of unhappiness or anxiety further diminishing personal resources to reinforce a state of negative feeling. And as with Sen's capability approach, the dynamic model renders functioning and subjective wellbeing as a state of emotions contingent on resources, both internal and external.

171 ibid
172 ibid
173 Juliet Michaelson, Sorcha Mahony and Jonathan Schifferes, Measuring Well-being: A guide for practitioners. New Economics Foundation, July 2012.
174 Layard, Richard. 'Measuring Subjective Well-Being' in Science 29 Jan 2010: Vol. 327, Issue 5965, pp. 534-535.
175 Juliet Michaelson, Sorcha Mahony and Jonathan Schifferes, Measuring Well-being: A guide for practitioners. New Economics Foundation, July 2012.

**Why measure wellbeing?**

Much has been contributed to academic literature in recent years on the importance of measuring the wellbeing of national populations alongside more established measures of social progress and economic development. While continuous GDP growth denotes a growing economy and wealth creation, it does not by itself constitute improvements in the quality of life or happiness of citizens living in wealth-creating societies.[176] Nor does the strong presence of external/objective factors, such as income, education and housing, or internal factors, for example good health, necessarily result in high levels of wellbeing. External factors may be deemed necessary but not sufficient conditions to yield positive levels of wellbeing in populations living in industrialised economies that might otherwise be assumed to enjoy high levels of life satisfaction.

Wellbeing has been shown to have a positive effect on good physical health and life expectancy, with evidence pointing to the power of positive emotions when it comes to reducing mortality and aiding recovery.[177] It has also been associated with positive functioning, good interpersonal relationships and the greater ability of individuals to cope with adverse events or challenging circumstances.[178] Wellbeing has a crucial role to play in preventative healthcare and indices to measure wellbeing offer vital information on the three limbs of emotions, function, and evaluation that make up personal wellbeing.

176 Layard, Richard. 'Measuring Subjective Well-Being' in Science 29 Jan 2010: Vol. 327, Issue 5965, pp. 534-535.
177 Xu, Jingping and Robert. E Roberts (2010). The power of positive emotions: it's a matter of life or death - subjective wellbeing and longevity over 28 years in a general population. Health Psychol. 2010 Jan;29(1):9-19.
178 Foresight Mental Capital and Wellbeing Project (2008). Final Project report: 'Mental capital and wellbeing: making the most of ourselves in the 21st century'. The Government Office for Science, London.

**How to measure wellbeing?**

There is no single set of indicators used to measure wellbeing. The ONS dashboard provides information on the four questions mentioned above measured on a scale ranging from 0 to 10, while the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) measures feelings, functioning and evaluation using 14 positively-worded questions assessed on a Likert scale to yield scores ranging from 14 to 70, with higher numbers indicating high levels of wellbeing.

Figure 34: Warwick-Edinburgh mental wellbeing scale

**The Warwick-Edinburgh Mental Well-being Scale (WEMWBS)**

| STATEMENTS | None of the time | Rarely | Some of the time | Often | All of the time |
|---|---|---|---|---|---|
| I've been feeling optimistic about the future | 1 | 2 | 3 | 4 | 5 |
| I've been feeling useful | 1 | 2 | 3 | 4 | 5 |
| I've been feeling relaxed | 1 | 2 | 3 | 4 | 5 |
| I've been feeling interested in other people | 1 | 2 | 3 | 4 | 5 |
| I've had energy to spare | 1 | 2 | 3 | 4 | 5 |
| I've been dealing with problems well | 1 | 2 | 3 | 4 | 5 |
| I've been thinking clearly | 1 | 2 | 3 | 4 | 5 |
| I've been feeling good about myself | 1 | 2 | 3 | 4 | 5 |
| I've been feeling close to other people | 1 | 2 | 3 | 4 | 5 |
| I've been feeling confident | 1 | 2 | 3 | 4 | 5 |
| I've been able to make up my own mind about things | 1 | 2 | 3 | 4 | 5 |
| I've been feeling loved | 1 | 2 | 3 | 4 | 5 |
| I've been interested in new things | 1 | 2 | 3 | 4 | 5 |
| I've been feeling cheerful | 1 | 2 | 3 | 4 | 5 |

Linton et al, in their literature review of self-reporting measures for assessing wellbeing in adults, argue that the multidisciplinary interest in wellbeing and its significance to different academic disciplines, health economics and clinical psychology to name but two, makes forging a consensus on what to measure and why a difficult enterprise. In their systematic review of instruments measuring wellbeing in the period 1993 to 2015, they identified 99 measures of wellbeing containing 196 dimensions of wellbeing.[179] The review signifies the enormous difficulty with condensing measures to propose a smaller set of uniform metrics given the different purposes for which indices are used and the dimensions of wellbeing relevant to specific academic disciplines. The breadth of metrics used seem to render an agreed definition or a unitary concept as challenging as it is undesirable and that well-being is perhaps better understood as a multi-dimensional concept encompassing "positive phenomena such as joy and social acceptance, negative phenomena such as anxiety and pain, subjective feelings and perceptions, and more 'objective' material circumstances or health states".[180]

179 Linton M-J, Dieppe P, Medina-Lara A. Review of 99 self-report measures for assessing wellbeing in adults: exploring dimensions of well-being and developments over time. BMJ Open 2016
180 ibid

Two facets of the Linton review that have acute relevance here are firstly, the absence of child and adolescent wellbeing instruments in the study, and secondly, details with respect to the inclusion of faith and spirituality in the assessed instruments over time. As Linton et al observe, since the 1980s, there has been a move towards incorporating spirituality into the assessment of well-being. Public Health England identify 'faith, hope and spirituality' and a 'belief that life has meaning' as positive contributors to building resilience in young people with mental health difficulties enabling them to cope with adversity and adapt to change.[181]

On the absence of child and adolescent wellbeing measures, the study focused on adult wellbeing measures and therefore instruments concerning child and adolescent mental wellbeing were removed as ineligible for analysis. Although, it is worth noting that, of the 3,800 items identified in the literature search, 1280 of which were removed as duplicates, the resulting number of instruments to be assessed amounted to 129, of which only 4 were removed for relevance to children and adolescents, not adults. The figures suggest research interest in child and adolescent wellbeing is a much newer development.

As Selwyn notes in a different review on measuring wellbeing, "Compared with the extensive development of adult measures of wellbeing that have used research and experimental trials, there has been far less work developing questions and instruments that are child appropriate."[182] Work in this area has been led by organisations such as The Children's Society and the ONS, with the New Economics Foundation widening its contribution to work on adult wellbeing measures to include measures focused on children and adolescents.

The Children's Society's Good Childhood Index covers children aged 8-15 while the ONS domains measuring wellbeing among children and young people is split according to the age cohorts 0-15 years and 16-24 years. The seven domains under which wellbeing among young people is measured by the ONS are:

- Personal Well-being
- Our Relationships
- Health
- What We Do
- Where We Live
- Personal Finance
- Education and Skills

181 Marilena Korkodilos. 2016. The mental health of children and young people in England. Public Health England, December 2016.
182 Selwyn, J., & Wood, M. (2015). Measuring Well-Being: A Literature Review. Coram Voice. Available at: http://www.coramvoice.org.uk/professional-zone/news/launchliterature-reviews-support-bright-spots-project.

# How do you define mental wellbeing?

The question 'How would you define mental wellbeing?' elicited 578 responses in total, with 149 participants opting to leave the response blank. Of those that were not in direct response to the question: 9 participants wrote "important", which can be read simply as an endorsement that the concept matters to personal health; and 130 participants misunderstood the question, returning an answer that variously described the status of their personal well-being.[183] 8 responses referred to the difficulty of defining the concept, or returned a "not sure" or "don't know" response. The section below summarises the 430 responses received.

As with the measurement of wellbeing, responses to the question on how individuals define mental wellbeing were not always singular or straightforward. Chiming with the difficulty of imposing a unitary definition on a complex, multifaceted topic, participants referred to wellbeing in a multiplicity of ways with some answers stretching to form varied permutations of the three limbs of emotion, function and evaluation. Unlike the Warwick-Edinburgh wellbeing scale, participants were not given a prescribed list of questions about feelings, function or evaluation from which to rate frequency of experience, but instead were invited to provide an answer to the question in their own words. While this approach has yielded a rich and detailed cornucopia of answers, it has also presented challenges to coding responses, particularly where answers have been broad or expansive and elision between limbs has occurred.

In analysing responses, we have not double-counted the answers where they have traversed more than one limb but have coded according to the primary component in each response. Thus, where a participant has answered: "Being happy and in control of all aspects of life. Social, emotional, physical factors etc all being at a satisfactory level", we have coded under the category 'emotion: happy/happiness'. The response is an example of a multifaceted approach with the emotion - 'being happy', and evaluation - 'in control', linked to internal (emotional) and external contexts (social, physical) and given a preferred state (a satisfactory level). The emotion and evaluation are inseparable from the context but for the purposes of our analysis, we have restricted responses to primary factors to unpack the layered understanding of wellbeing among young Muslims. The primary factor forms the first layer, and the basis of the coding method, with subsequent layers sometimes providing context to give further meaning to the factor, or broadening the definition to incorporate new layers as other secondary and tertiary factors are added. So, in the example above, "Being happy" is understood not just as an emotional state, but the state from whence feelings of being 'in control' follow to affect a balance between 'social, emotional and physical factors' such that all align to 'a satisfactory level'. Being happy is central to the subsequent developments that the participant associates with a conception of wellbeing and we have coded this accordingly.

Coding by the primary factor is not to diminish the significance attached to other limbs, or to context provided by participants in which the factor is given a role or a function. Given the limits of time and resource, manual coding by primary factors has been chosen as a basis of analysis to enables the identification of key factors that shape young Muslims' understanding of wellbeing. A more time-consuming though worthwhile attempt would be similar to that adopted by Linton et al, with responses coded according to all factors and limbs referenced in each individual response. That has not been possible in this study.

The most common understanding of wellbeing focused on the "emotion" aspect with more than half of participants (56%) referring to some form of emotional state as central to wellbeing. Responses frequently associated wellbeing with emotions as being in a state of stability or balance, of being able to navigate "peaks and troughs" without experiencing emotional disruption. Maintaining a balance and being able to "manage extremes in emotions" was highlighted while others referred to emotions functioning to offer individuals "resilience" to withstand circumstances and outcomes beyond their control. The absence of negative emotions was cited with emotions attached to feeling "secure with vulnerabilities" or "insecurities", and enabling individuals to feel "confident in their own skin" or "safe in your skin".

183 Where respondents answered with details of their personal state of wellbeing, responses varied between those whose wellbeing was described as on a sliding scale (excellent, good, stable, average, ok, struggling, fluctuating, not great, unwell, bad, poor, terrible) and those who declared an illness (anxiety, depression, bipolar).

Control was another factor associated with emotions in places where the answers elided into concern with function, with participants referring to possessing "mastery" over emotions, or being able to exert "control" over their emotions in order to "think clearly", be "able to focus", or being comfortable with emotions so that they do not "interfere with or limit daily life".

In very few instances was frequency, as used in the Warwick-Edinburgh scale, referenced when describing emotions; one participant spoke about wellbeing as "feeling good all of the time" while another said it was about "feeling good most of the time".

Other participants explicitly named positive emotions as a defining characteristic of mental wellbeing with feeling "content" (45), at "peace" or "calm" (38), being "happy" or feelings of "happiness" (41), and feeling "positive" (11) making up the other two thirds of responses in this category. Peace and calm were often coupled in the responses, with the two emotions regularly used together in the same sentence.

*Sense of calm in my mind and soul*

*Being calm and peaceful*

*Inner peace within your mind, fully accepting who you are*

*A state of internal peace*

*Someone who's happy within themselves*

*Being happy and content with yourself and your life*

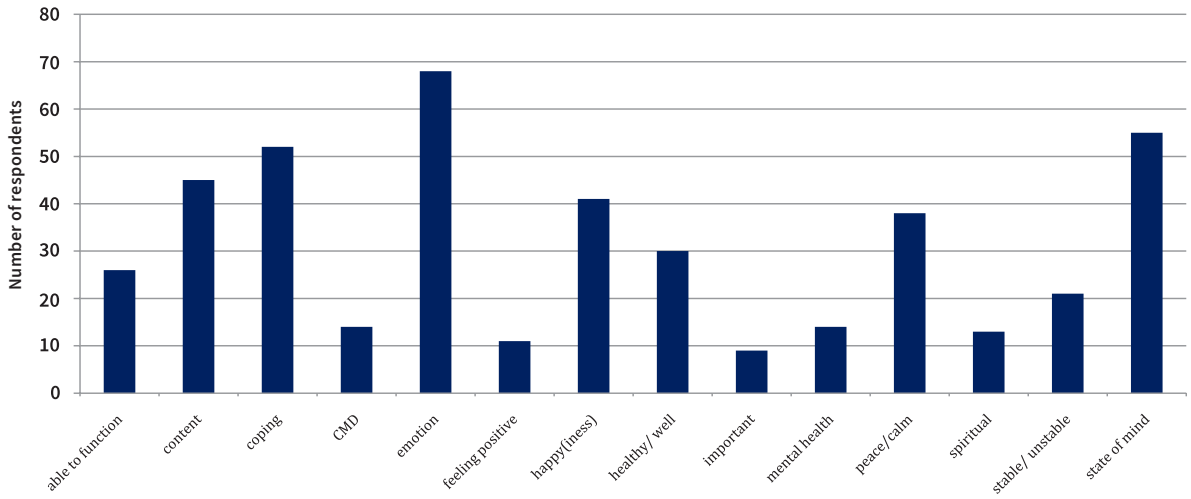
*Feeling happy and good from the inside, not just physically*

*The level of contentment you have about your life and surroundings*

*Contentment with the present and hopeful towards the future*

The common mental disorders that were linked to what it meant by mental wellbeing was noted as being the absence of anxiety, depression or stress as a physical state. These made up 3% (14) of the responses with participants saying not living with or experiencing these common mental disorders was essential to wellbeing.

Figure 35: Question: How would you define mental wellbeing?




Other physical states that were associated with wellbeing were "being stable" (21 responses) and "being healthy or well" (30 responses). As with the use of "balance" in answers which referenced emotions, stability was referred to as a state in which an individual attained an equilibrium within that could support daily functioning without veering towards disequilibrium or experiencing extremes. Mental stability was frequently noted as an even keel that prevented an individual from being destabilised by events, emotions or experiences. The inverse was also mentioned in a couple of the responses with answers stating not "being unstable" as key to wellbeing. Thus, individuals said mental wellbeing was:

*stability and ability to stay grounded and content in any situation.*

*Mental stability and contentment.*

In relation to other attributes, individuals variously noted the importance of a healthy state of mind as fundamental to wellbeing:

*Being mentally healthy*

*Having a healthy and good mental state*

*A healthy state of mind*

*State of normal and good health*

*Being psychologically healthy as well as emotionally*

And health was also associated with function such that a healthy mind was one capable of "dealing with issues" and "making healthy decisions in different emotional states". After emotion, whether nondescript or defined as either positive or negative, the second most common response to what it meant by mental wellbeing referred to one's state of mind. Here, some individual responses were, again, without further elaboration, with several simply stating mental wellbeing was "a state of mind". In other cases, the state of one's mind was linked to a positive disposition, "positive state of mind", and to a sense of "balance" or "soundness". The state of mind was further associated with function, where mental wellbeing was about how one's state of mind enabled or hindered function:

*state of mind, being able to make rational decisions, react appropriately to stresses in life and know how to cope with them.*

*When a person has the right state of mind. They can deal with certain situations and cope with them well.*

*The well-being of your state of mind and being able to deal with different stress and other issues.*

*Mental well-being is about an individual's mind and the current state it's in - also referring to the mindset a person has to deal with challenges.*

There were few instances where the state of mind was overtly linked to evaluation, although a couple of participants did state mental wellbeing was:

*A state in which every individual realizes his or her own potential.*

*Having your brain be a safe space for your whole being.*

After emotion, a good proportion of responses linked mental wellbeing to the second limb: function (17.6%); the ability to cope (52) or to function (26) in daily life. Coping was frequently associated with "stressors" with participants mostly saying mental wellbeing was about being able to deal with stress factors in daily life, and a minority referring to stress arising from unexpected situations. The ability to cope was presented as both as active disposition, one's capacity to withstand daily challenges and deal with them, and as a mechanism, where coping was spoken of as a strategy for when "your mental health isn't okay" or "to overcome periods of stress and depression".

Being "able to function" was used in ways analogous to being able to cope, with most participants saying mental wellbeing was about being able to get on with day-to-day life and activities.

A small number of responses (14) related wellbeing expressly to a mental state, noting that the concept was defined as: "the state of one's mental health", "how good my mental health is", "the care of one's mental health", or "the state/condition regarding your mental health".

An almost equal number (13) associated wellbeing clearly with spiritual or faith-derived beliefs with the concept concerned with the mind and "the soul" or "spiritual self" or a sense of "wholeness". Other responses in this category were more explicit in their reference to faith and beliefs with responses such as:

> ***Contentment in Allah's decree, being grateful for what you have, being optimistic for what the future holds, holding yourself accountable but not being harsh or judgemental towards others.***

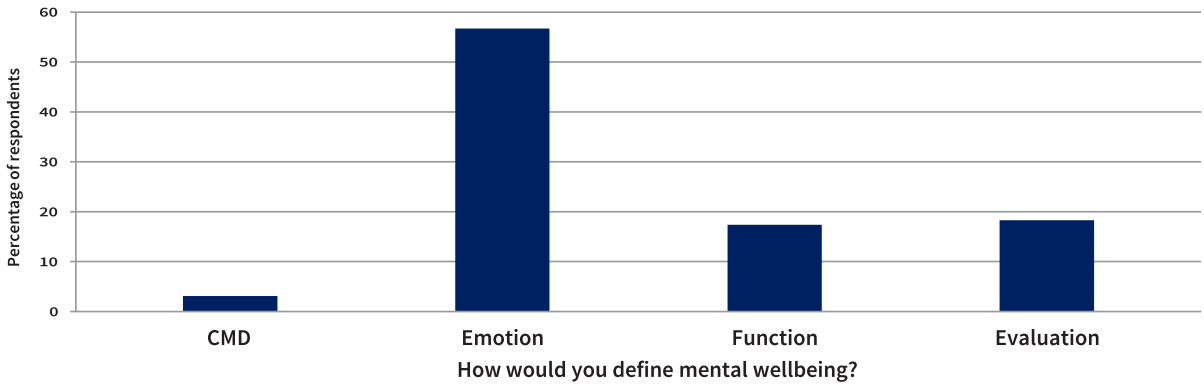
> ***Mental wellbeing, as a Muslim, especially, is when I am able to trust entirely in Allah, and fully admit to contentment, self-care, self-respect, and daily prayer and taqwa.***

> ***Mentally well person respect views and thoughts of everyone and have trust in Allah.***

Though the sample includes a proportion of individuals who did not self-describe as observant Muslims, there was only a single response that negatively linked spirituality and wellbeing with one participant defining wellbeing as the "rejection of all religions".

A summary of the three limbs and the responses by individuals on how to define mental wellbeing is shown in the graph below.

Figure 36: Question: How would you define mental wellbeing?




An interesting observation on the survey data was the low number of responses that explicitly referred to themes of faith or spirituality when defining mental wellbeing. In the vast majority of cases, wellbeing was defined in psychosocial, emotive, social and functional terms, with individuals referring to wellbeing as a set of emotions, either positive emotions (happiness, contentment) or the absence of negative emotions (feeling "stable" or "balanced" and feeling "calm"); functional capability (being "able to cope" or "to function" with day to day life); social interactions, wanting to be around people and not be isolated; and evaluative elements relating to "state of mind", of feeling able to reach one's potential, and aligning "internal and external truths".

While the low number of explicit references to faith and spirituality on what is meant by mental wellbeing contrasts sharply with the frequency with which faith is mentioned when it comes to having services that are faith and culturally sensitive, or how likely an individual is to turn to faith for support when dealing with a mental health struggle, as we see later in the analysis, the tendency to relate wellbeing to emotions, function and evaluation can be understood in two ways. The first is that young Muslims are competent in mental health literacy and are able to express an understanding of mental wellbeing without needing to resort to an exclusivist set of terms based on religion. Their framing of wellbeing in terms of emotions, function and evaluation denotes strong harmonisation with familiar measures used to assess wellbeing that renders both their self-understanding and objective criteria mutually intelligible. The second is that, while faith and spirituality are not explicitly mentioned when it comes to defining wellbeing, the limbs across which their responses fall are not, however, divorced from religion as a resource to attain a desired state, whether this relates to emotions, function or evaluation. In this sense, wellbeing is spoken of using terminology familiar to a mental health practitioner, while the quality of mental health support needed to attain or address deficiencies with emotions, function and evaluation leans more heavily on faith-based tools and faith-sensitive methods.

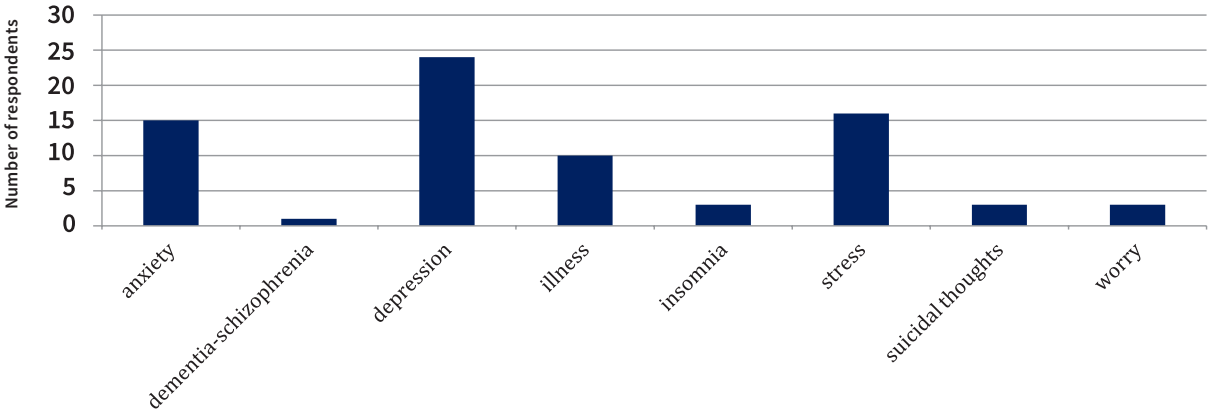
# How do you define mental health struggles?

Following on from the question about mental wellbeing was a question asking participants to define mental health struggles. Again, the question included no prescriptive list of items or illnesses from which to select, and participants were given free rein to write in their responses. The answers were coded according to primary factors and based on the three limbs of emotion, function and evaluation. Interestingly, in this segment of the analysis function was a more common a response than emotion, while evaluation, of an individual and social type, was also strongly present in the sample.

The overall number of responses received was 527 with 153 individuals providing no response to the question, 13 "don't know/not sure", 3 saying it was "important" and 17 that it was "difficult" to define. 15 participants misunderstood the question and responded with their personal struggles.

Common mental disorders and more serious conditions were named in 14% of the responses, with stress, anxiety, depression, dementia-schizophrenia, insomnia, suicidal thoughts and worry all being expressly mentioned. The graph below summarises the disorders named by individuals. Common mental disorders appear more frequently than more serious conditions. In only one instance was there conflation between a mental health condition and a physical illness with one participant naming dementia and schizophrenia as a hyphenated illness.

Figure 37: Question: How would you define mental health struggles?




Emotion was linked to mental health struggles far less frequently than it was to wellbeing, with 23.7% of responses referring to emotions when it came to defining a mental health struggle. Emotions that were explicitly mentioned included "conflict", "content/ment", "pain", and feeling "unhappy":

*An inner conflict or the inability to enact your will.*

*Mental health struggle would be when you are struggling to feel content.*

*Loss of contentment and peace.*

*Being in pain mentally.*

*Difficulty experienced mentally... mental pain which can also be physically debilitating.*

*Unhappy and unable to function as usual.*

*When you have to carry on with life despite an unhappy mindset.*

In other cases where the emotion limb formed the core basis of the response, it was connected to function and evaluation, with individuals referring to emotional states which hindered every day function, or quelled motivation. Several responses noted an inexplicable nature to the emotional frame of mind, with individuals noting struggles to mean "Feeling down without being able to pin point why" or "random mood swings or sudden feeling of deep sadness for no apparent reason".

Negative emotions were more commonly referenced and longevity of negative feelings seen as a recognised feature of mental health struggles:

*When someone isn't feeling great for prolonged periods of time e.g., extreme sadness, lack of interest in hobbies, lack of motivation.*

*A prolonged period of negative emotions, and (but not necessarily) a diagnosed mental illness.*

*A sustained period of feeling distressed.*

*Long periods of unstable feelings and emotions affecting the ability to function.*

*A persistent, deficiency in mental wellbeing*

And negative emotions were also linked to mental states with the absence of "peace of mind" or "inner peace" and feeling "unbalanced" or "unstable" associated with mental health struggles; the perception that without balance one is left "vulnerable", "unsettled" or in "chaos".

*When you reach the tipping point*

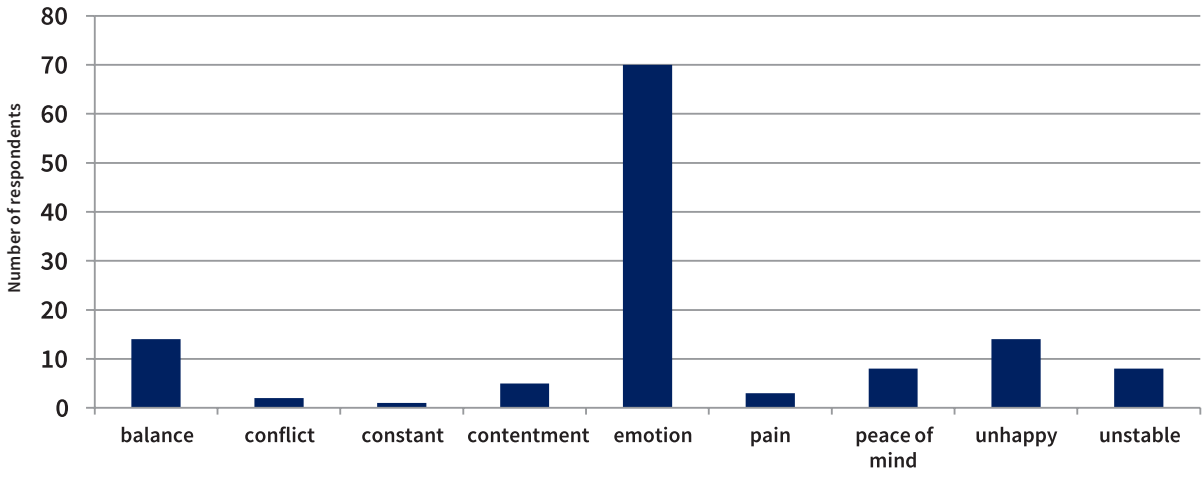
*Not having a balance when it comes to emotion & inability to deal with difficult situations*

*There is an imbalance emotionally, spiritually or physically*

*An imbalance in the mental state of a person by the enlargement of negative emotions*

*When our inner states both mental and emotional have tilted the scales too much to one side, having a significant impact on your daily living as a whole. You do not feel entirely like 'you' during a mental health struggle and are seeking a way to bring the balance back.*

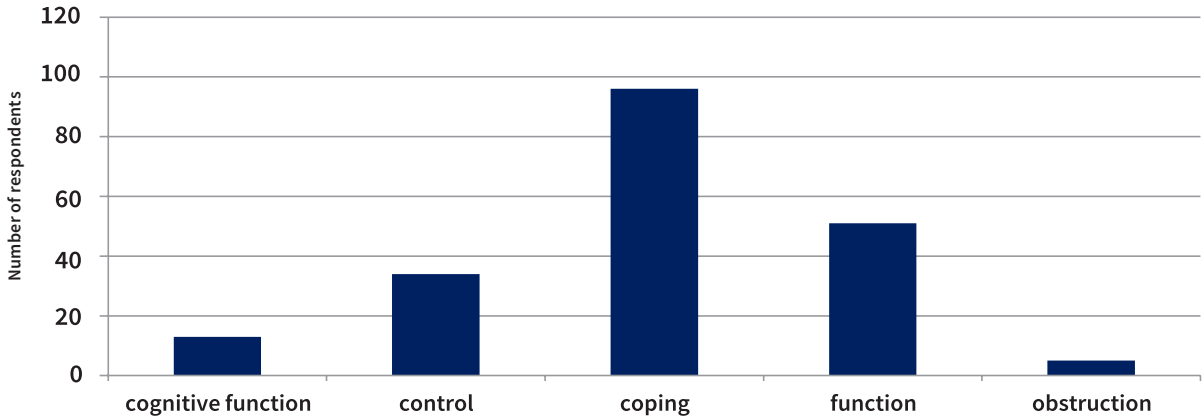
Figure 38: Question: How would you define mental health struggles? (limb: emotion)




Function was the most common connection made when considering what it meant by mental health struggles, with 38% of participants referring to function as constitutive of mental health struggles and its effects.

The majority of those who said mental health struggles were linked to functional capacity referred to coping (92) or to function in a generic sense (50) with a further 13 specifically noting "cognitive function" as a key component of what it means to experience mental health struggles.

Figure 39: Question: How would you define mental health struggles? (limb:function)




The two most common responses in this category, as with mental wellbeing, relate to one's ability to function and cope with situations. Function was mostly used in connection with daily activities to describe the inability to carry out day to day tasks:

*Daily disability*

*Daily life being affected by your mental health*

*Struggling with day-to-day tasks you were able to do before, noticeable and more persistent changes in mood which cause distress*

*Barriers to basic function*

*When everyday tasks or functioning is impacted but not by a physical injury or disease.*

*Interfering with your daily life and preventing progress with life*

Participants also spoke of the distress wrought by mental health struggles through use of singular adjectives describing physical states induced by the struggle. Words such as:

*Crippling*

*Paralyzing*

*Collapsing and suffocating*

*Life threatening*

Other physical attributes used to describe the distress experienced when suffering mental health struggles were feeling "trapped in your own body", facing "a rock on the road", or enduring "mental blocks" or "mental barriers" that obstructed the ability to "lead a normal life".

Several others went beyond the everyday challenges to functioning to refer to mental health struggles as impacting social relationships and affecting social and economic outcomes in the long term.

*Having a severe or enduring MH problem that gets in the way of you doing things and holding down secure and healthy relationships*

*An individual with struggling mental health would take a toll on their life, and daily activities and relationships with others.*

*Mental health struggles affect the vast majority if not all people and broadly refer to a variety of mental health setbacks which have a continuous and long-term impact on your livelihood*

*Not feeling mentally stable. Your mental state not allowing you to carry out your usual tasks. A loss of interest in life, activities and seeing friends*

*It has a major impact on your entire life*

Where cognitive function was specified, it was related to a tendency for “irrational thoughts” or to being unable to “perceive things clearly”, where the mind was stuck in “a dark, grey cloud” or frustrated in its capacity to “grow and develop”.

Coping was a frequent response with mental health struggles defined largely as the inability to cope. The scenarios in which coping was addressed varied from “daily life”, where mental health could impede the carrying out of everyday tasks such that “the ordinary becomes difficult”. Or to life in general where “stress” and “stressors” were identified as obstacles hindering functionality. Interestingly, participants did not name any specific stressors in their responses. Other situations where an inability to cope was mentioned related to more internalised barriers with the inability to manage or overcome one’s “thoughts and emotions”. Trigger events were stated in a few responses, where coping was directly inferred as being obstructed by an event or the memory of an event:

*Struggling with processing emotions and events healthily*

*Unable to cope during a difficult time, break down or bounce back from a stressful situation*

*Unable to cope/overcome stressful events in life, and difficulties in performing everyday activities*

*A struggle to accept the past*

*A hardship one is going through possibly due to an uncomfortable experience they feel is way out of their hands to deal with, a trauma or trigger even that has set them to struggle and feel uneasy*

Control (33) was the fifth subset within the category on function with participants speaking about a “lack of control”. The objects of control mentioned were at times internal, the sense of an individual’s “thoughts and feelings” being beyond their control to the point where it affects their quality of life, as well as external, with participants noting the difficulties arising from situations over which they lacked control; “When you think everything is against you” or

“Feeling things not going right or their way”. The ambiguity of identifying the problem and feeling a loss of control as a result was also stated with participants noting mental health struggles as:

*Not being able to understand what you’re feeling*

*Unexplainable*

*Being unable to identify the issue, when you just don’t feel 100%*

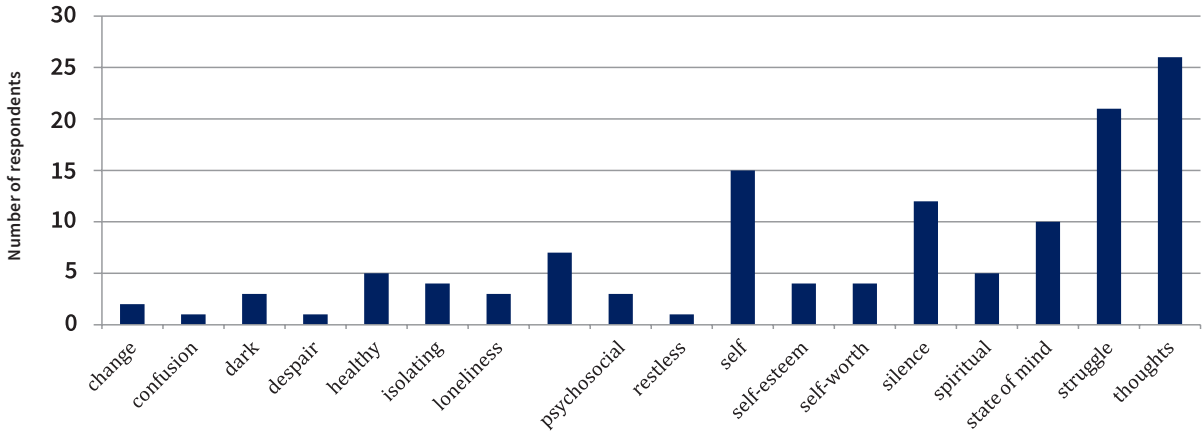
*When you’re not sure what’s happening and you’re confused and blaming everything on yourself*

One response captured the way individuals can sometimes perceive control as a self-reinforcing cycle describing mental health struggles as: “Thinking that everything is getting on top of you, no one to talk to, feeling like the world will be a better place if you weren’t in it”. The sense of being overwhelmed and lacking control coupled with isolation, either having no social outlet to talk about one’s feelings or having no access to mental health support, can lend itself to a feeling of self-abandonment or reneging any desire to possess control over the self and instead imagine a world without the individual in it. Such a downward trajectory is not only dangerous but illustrative of the importance of mental health support, where an interjection at a point in time - “no one to talk to” - can make all the difference to how a person comes to deal with the initial problem of feeling overwhelmed.

What emerges from the analysis of the function category is the debilitating nature of mental health struggles and the immediacy of its impact with daily life being widely perceived as suffering significantly as a result. The breadth of areas function impinges on, from feeling thoughts and emotions are out of one’s control, or irrational thoughts impeding activity, to feeling a more profound sense of frustration at being trapped or obstructed and unable to move forward, shows that mental health struggles are not confined to the state of one’s mind or to an inner coherence, but have huge ramifications for the way in which young people go about their lives on a daily basis.

The final limb studied was an evaluation. In this category, we looked at perceptions of life quality and life satisfaction, as well as eudemonic attributes; the imputation of value or meaning to life . The graph below summarises the primary factors identified in the analysis.

Figure 40. Question: How would you define mental health struggles? (limb: evaluation)




When it comes to assessing quality of life, participants referred to mental health struggles as "battles" fought whether "continuously" or "daily" or "internally"; participants spoke of this "struggle" (19) as implicit to notions of poor mental health. "Fighting to stay normal" was how one participant put it. Similarly, participants spoke of the absence of or struggle to maintain a healthy mindset (5) as symptomatic of mental health struggles.

"State of mind" (10) was another aspect where life quality was rendered deficient due to the mind "not being good", or experiencing "internal chaos". In one case state of mind was linked to external factors as well as internal struggles with one participant defining mental health struggles as "when you struggle to maintain a good psychological state due to biological and environmental reasons".

Thoughts (26) were another aspect which impinged on quality of life with participants referring to "disrupted thoughts", "recurring thoughts", keeping track of "inner thoughts" and "overthinking" as all affecting an individual's health leaving them "unable to stop crying" or "struggl[ing] with sleep". Further aspects in which thoughts were described as having an incapacitating impact were:

*Struggling to make sense of your thoughts and feelings, your surroundings*

*Scattered thoughts, undefined self*

*Getting out of bed with bad thoughts*

*Not knowing what to think and doubting everything. No desire to do anything of substance. State of disarray*

*Torture by your thoughts*

*Wherein you feel trapped by your thoughts.*

The challenges to life quality were also set out as innate with participants referring to the various existential difficulties faced by the self (15), where "being" oneself, or "feeling like" oneself, was an ongoing struggle:

*An inability to feel like yourself and being able to function properly Struggle to be yourself*

*Not being able to be yourself constantly*

*Battle with your inner self that Muslim family don't understand*

*An inability to feel like yourself and being able to function properly*

*A fight against you*

Other ways in which the self was framed in the responses was in relation to feelings of self-esteem (4) and self-worth (4). Participants spoke of not being able to "accept themselves" or "hating" themselves, of feeling "like a failure" or lacking confidence and self-esteem.

Experiencing a profound negativity in outlook and motivation (7) was another way the impact on quality of life was captured with the effects felt on day-to-day activities. Analogous sentiments were also framed as "confusion with reality", where the dissonance between what is and what is perceived forms the basis of the struggle.

A prevailing darkness (3) was a further way in which negativity was framed with three participants describing it as variously as a "dark cloud", a "dark hole", or simply "dark". The variances are relevant when one considers the nouns used; a cloud as something that hovers over a person while a hole is a subterranean setting into which something has fallen. Another participant described it as "despair". In all cases, the implications for life satisfaction are implicit in the gloomy forecast.

Experiencing an altered state was also mentioned, with participants denoting the shift in personality and behaviour that manifests with mental health struggles. Two participants spoke of "Change in how I was to how I am" and "Change of personality or behaviour". A third spoke plainly of feeling "restless".

A sense of loneliness (3), feeling isolated (4) or being shunned into silence (12) with no outlet to talk about one's struggles were other ways in which participants framed how mental health struggles can impact on quality of life. Treading a lonely path and withdrawing from social contact was how some described it, while others referred to "not having any one to talk to" about their troubles or "not being able to speak up" about what they were experiencing. Only one participant spoke of the silence as emanating from mental health struggles being a "taboo" subject.

A minority of responses related the impact on quality of life as originating in wider society with mental health struggles seen as emerging from:

| | |
|---|---|
| *Communities* | *Structural and institutional racism* |
| *A production of the society we live in* | |

As with wellbeing, few participants explicitly framed mental health struggles in relation to faith and spirituality. Only five participants alluded to spiritual aspects, with three speaking of mental health struggles as a state of disharmony involving the mind, body and soul or an "incongruence within the soul" while two others spoke in more religious terms of mental health struggles as "a test". The low rate of responses that veer toward language that is laden with spiritual connotations suggests young Muslims are more willing to speak of mental health struggles in parlance that is not parochial. There were no allusions at all to sentiments that feature in some of the literature on Muslims and mental health, such as references to "jinn" or to "black magic". The relatively benign mention of mental health struggles as "a test", itself quite small in the overall sample, is a minor observable hint to a spiritual context.

As with the primary factors mentioned in the question on well-being, what we learn from the way young Muslims frame mental health struggles is their confidence to articulate this in language that is universal. What we also learn from the responses is the sheer breadth of complex emotions and states of being that mental health struggles generate and its impact on how young Muslims function in their daily lives. The dark, pessimistic outlooks that can inhibit aspirations and the debilitating effects of subdued functionality or confidence in capability that comes from feeling unable to cope, reveal the extent to which young Muslims can be affected by mental health struggles.

In a broader context, feelings of not being able "to be" or "to accept" oneself and lacking self-esteem and self-worth present issues for both Muslim communities and wider society. The expectations placed on young people, at a communal and societal level, can create difficulties for self-acceptance, which in turn can affect their feelings of self-esteem and self-worth. At the same time, where communities such as the Muslim community itself struggles against self-acceptance, with Islamophobia causing states of exclusion and marginalisation from the mainstream, one can reasonably expect that young Muslims would also be affected by the currents of hostility and disdain directed at their group in society. Consequentially, we can come to expect feelings of self-worth and self-esteem being cultivated and informed within this harmful milieu. Young Muslims face a dual challenge of navigating their communities and wider society. What we can take from the evaluation limb of the responses is that both contexts are vitally important to the health and well-being of young British Muslims.

# Faith and faith/culturally-sensitive mental health services

The survey asked a number of questions that are concerned with faith in mental health service provision and as a source, or not, of individual strength and resilience with participants being asked:

1. **Would you prefer to see a Muslim counsellor/ therapist?**
2. **Is it important to you for mental health services to be culturally/faith sensitive?**
3. **When you experience mental health struggles, how likely are you to turn to your faith?**
4. **I believe faith has a positive role in supporting my mental wellbeing.**
5. **Can you share an example of when your faith helped you with a mental health struggle?**
6. **Can you share an example of when your faith hasn't helped you with a mental health struggle?**

Questions 1 and 2 offered a binary option (yes/no) with an 'other' category followed by a dialogue box in which participants were invited to share their reasons for selecting their answer to the preceding question. Questions 3 and 4 were measured on a Likert scale with the first set of options as Extremely likely, Likely, somewhat likely, Unlikely and Never and the second as Strongly agree, Agree, Neutral, Disagree and Strongly disagree. Questions 5 and 6 offered dialogue boxes for participants to enter open-ended responses.

As with preceding questions in the survey, participants were not compelled to provide an answer to any question they chose to skip. The samples for the different questions therefore vary in size although in all cases the majority of participants chose to answer the question.

One particular question that generated critical responses was question 2, with participants keenly pointing out in their open responses the failure in the survey design to distinguish between faith-sensitive and culturally-sensitive services. While the question framed the sensitivity as a conflation making no distinction, participants were eager to point out that, when requiring services to respond to particular needs, faith and culture deserve separate, unrelated attention. The distinction made is all the more pertinent given the ethnic bias present in this particular sample where references to 'culture' invariably refers to south Asian (Indian, Pakistani, Bangladeshi) culture.

What is most striking in the data deriving from these questions is the strong presence of faith and spirituality in the positive responses. In the early questions probing mental wellbeing and mental health struggles, faith and spirituality were uncommon in the responses given by participants. But in questions seeking preference or importance attached to the delivery of services for addressing mental health struggles, young Muslims expressed a strong preference for faith and spirituality to be integrated. The results show a statistically significant correlation between those who have experienced mental health struggles and a preference to see a Muslim therapist or counsellor, even among those who self-describe as not being particularly observant of religious practice. The results also show a statistically significant correlation between those who have experienced mental health struggles who believe it is important for mental health services to be culturally/faith sensitive and who believe faith has a positive role in supporting mental wellbeing. The strongest correlation found was in relation to the likelihood of turning to faith when experiencing mental health struggles. Here, among those who have experienced counselling or therapy, those who expressed a preference for a Muslim therapist/counsellor, those who felt it important for mental health services to be culturally/faith sensitive and those for whom faith has a positive role in supporting mental wellbeing, strong correlations were established with the likelihood of turning to faith when faced with mental health challenges.

The foregoing analysis presents a picture of young Muslims expressing their understanding of mental wellbeing and mental health struggles according to the three limbs of emotions, function and evaluation. The next section examines what role, if any, faith has in addressing emotions, function and evaluative aspects that can affect mental health.

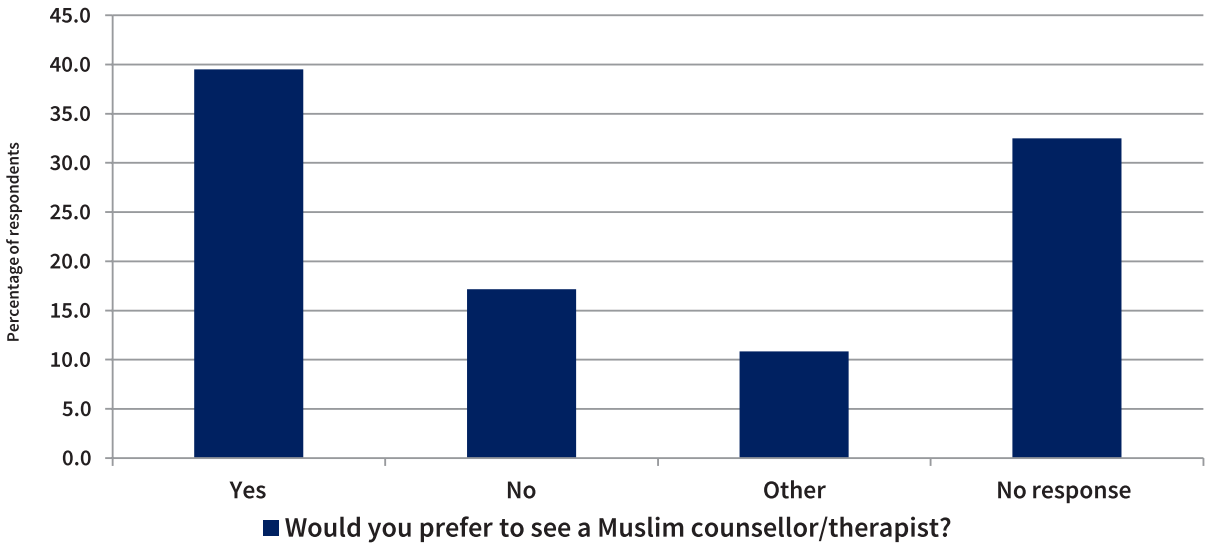
# Would you prefer to see a Muslim counsellor/ therapist?

A question about whether participants would prefer to see a Muslim counsellor or therapist followed questions which probed whether participants had experienced counselling or therapy and how frequently. The ordering of the questions is relevant for the purpose of positioning the inquiry. Asking whether participants would prefer a Muslim counsellor or therapist places the onus on a matter of preference taking as its starting point the basis of whether some form of counselling or therapy had previously been experienced. The issue of preference arises, in this instance, from an assessment of past experience. Given the number of participants in the survey who had undergone counselling or therapy, to different extents, the question offers some insight into their past experience and future hopes. For those who experienced no counselling or therapy at all, the question eliciting reasons for their preferred choice tells us something about what approach participants might take to counselling should they find options that suit their preferences.

Nearly two in five participants said they would prefer to see a Muslim counsellor or therapist, 39.5%, with less than one in five saying no, 17%. Around a third of participants chose not to answer the question 32.5% and 10.8 per (79) cent selected 'other'.

38 of the 79 expressed no preference, or were indifferent to the background of a counsellor or therapist, 19 said they were not sure or that 'maybe' they would prefer to see a Muslim counsellor or therapist. Of the remaining 22 responses, most were conditional - some participants stated the background of a counsellor was contingent on other factors such as whether the counsellor was 'non-judgemental', or 'unbiased', or whether the counsellor was 'trust-worthy', 'supportive' or possessed of adequate 'cultural competency'.[184] Others referred to the struggle faced determining whether the background was relevant, such as a Muslim counsellor "who understands LGBTQ+ and racial issues".

Figure 41. Question: Would you prefer to see a Muslim counsellor/therapist?




Participants were subsequently asked to elaborate on their response regarding preference. Of those who said 'yes' they would prefer to see a Muslim counsellor/therapist, their reasons were overwhelmingly related to 'sensitivity'; spiritual, cultural, linguistic and ethnic. Participants spoke of the desire to seek treatment without having to 'explain' themselves in the process, of being 'understood' more easily by a counsellor who is able of 'relate' to their cultural, religious and ethnic background, someone who could appreciate the difficulties encountered in contexts where mental health can be seen as a stigma.

*It would be good to have a Muslim counsellor who can speak to you knowing what it is like being a practising Muslim in the west with the everyday struggles.*

*I felt like my counsellor didn't really understand me and this was due to cultural and religious differences. For example, some of the things the counsellor advises me to do were not religiously acceptable. Ultimately I felt that religion and getting closer to God helped me more than my counselling and if my counsellor was a Muslim I feel like I would have been treated a lot quicker*

*More understanding about where I am coming from and perhaps will provide some advice derived from religion too. I once went to a counsellor who didn't understand that doing my prayers gave me some relief from stress.*

*They would have a better understanding of the issues I face - without me having to explain them.*

*It is much easier to speak freely with Muslims, and they may understand that my worries are not from "Islamic oppression," as other therapists think.*

*Can relate to upbringing in Islamic household and the stigma of mental health issues.*

*I went to therapy for my eating disorder/ depression and although she was very good and helped me to beat my eating disorder, there were limitations in how much she could help me because she wasn't Muslim. She didn't know how to respond when I said I've stopped praying or I'm blaming God all the time. Mental health struggles can affect you spiritually and it would be nice to have a therapist who could help me without judgement regarding those issues.*

*They may have better understanding of my religion, most of my life is based around Islam for example when I am upset, I would never resort to drugs or alcohol. My friend would be able to provide me solace in the sense that they may be able to say things like "Allah does not burden a soul beyond what they can bear". Islamic reminders and getting advice from people who understand me on a spiritual level helps. I would rather get that sort of help than be given x amount of medication and be diagnosed with mental health problems. plus, I would rather get advice from people I share a bond with than have traumatic experiences brought up and be constantly asked "and how does that make you feel?"*

A smaller proportion gave reasons that were overtly spiritual with references to using

'Islamic teachings' in therapy, or guidance from 'deen' (religion), 'shari'ah' (legal codes), and sacred texts, both the Qur'an and the Prophetic traditions (Sunnah).

*I feel a Muslim would use Islamic teachings as the basis of the therapy*

*I believe cure comes from Allah. I would appreciate someone who understands that too.*

*I would like Islam to be a major part of the resolution of my problems*

*A Muslim Counsellor can follow the Qur'an and Sunnah and it is only through turning back to Allah that things have got better. Islam gives reassurance in knowing my greater purpose in life, so I feel a Muslim counsellor can come back to this. I will also be able to relate with a Muslim counsellor*

Several responses referred to matters of trust with a Muslim counsellor being preferred for the 'ease' of talking to someone of that background and the 'comfort' derived from sharing the faith characteristic with a counsellor.

Of those whose response was 'no', the most common reason for not preferring to see a Muslim counsellor was the fear of being judged.[185]

*Fear of judgement and/or being preached at*

*Muslims will judge me from a religious point of view and what's haram rather than considering my feelings*

*Religion shouldn't matter, I think you might actually feel a little judged if they were Muslim.*

*They're often judgemental and patronising. It's impossible to open up to them.*

The second most common reason was about professionalism. Most participants felt the faith background of a counsellor immaterial compared to the quality of treatment provided, whether Muslim or not, participants wanted someone who was professional and competent whatever their background. But there is evidence that faith and professionalism can be seen as mutually exclusive with some of those who said no stating they would doubt the professional competence of a Muslim counsellor or feared a palpably religious outlook devoid of medical training:

*I feel like a Muslim therapist will just tell me to read the Quran and I'll feel better which is a helping factor but there's more needed*

*I feel like they would only use religion to try to help me (e.g., "God has faith in you to get through this, it's a test of faith, etc") rather than having a psychological outlook of it.*

*I don't think Muslims are rational and able to differentiate a mental health issue and strength of imaan.*

*I feel a Muslim counsellor may assume everything to be a spiritual problem.*

Another area where the professionalism of Muslim counsellors was questioned was in relation to bias. If a Muslim counsellor was preferred among those who said yes for reasons connected to sensitivity and understanding, for those who said no the converse was true; they felt Muslim counsellors would display forms of overt bias towards religion that would cloud their judgment and affect their ability to meet a patient's needs.

*I often find that Muslim professionals still hold on to their faith and values and look at your problems through the lens of a Muslim and not a mental health professional, there's usually a lot of bias*

*Some of the mental stresses come with being a Muslim woman and I'm weary of how much a Muslim therapist will be able to offer an unbiased opinion and assessment if it seems to go against the typical role expected of a Muslim female*

*I prefer my counsellor doesn't take any sort of religious perspective or bias; I understand how to use traditional therapies. What you want from a counsellor is modern therapy*

*I feel like their opinion would be biased on the religion. Most the support would be on how to improve the iman or become a better Muslim rather than the actual problem*

*They might recommend praying more or something*

185 Similar findings were also reported in the study by Mir et. al., 2015.

Among those who had experienced counselling or therapy, the response to whether they would prefer to see a Muslim counsellor was largely in favour; of the 243 participants who had experienced counselling, 55% (134 participants) said they would prefer a Muslim counsellor compared to 28% (69) who said no, while 16% (39) said 'other'. For those choosing the 'other' option, most were indifferent or unsure about expressing a preference stating 'I don't mind' or 'Unsure'.

Participants who had experienced longer stretches of counselling were also more likely to say they would prefer to see a Muslim counsellor; 200 participants had experienced counselling for a few sessions or numerous sessions over months and years, over half, 54.4% (109 participants) said they would prefer to see a Muslim counsellor while 29.5% (59) said no and 16% (32) selected 'other'.

Again, the reasons for preferring a Muslim counsellor were predominantly articulated in terms of 'understanding' nuances of cultural competency and a regard for the role of faith in an individual's life and as a source of strength when confronting mental health struggles:

*A Muslim therapist would know the stigma of feeling depressed and anxious and difficulty of speaking up especially with community shaming us*

*The therapist didn't understand my anxieties about being a Muslim woman in a workplace and going to interviews wearing hijab etc. She also didn't understand fully how powerful my faith was and that was the only thing keeping me from ending my life*

*I feel like they'd understand the guilt of depression as I question how grateful I must be to God if I'm depressed*

*I saw a therapist for a few sessions relating to my sexual abuse. I did not feel she understood the cultural implications of my experience. for example, she once referred to me as Pakistani where I am Bengali. she also did not understand the intricacies of shame and why it would have been weird for me to have a BF / pre-marital relationship etc.*

But the reasons for saying 'no' or 'other' were equally strident, with participants disclosing past experiences that have had an adverse impact:

*Have had Muslim therapist who told me I was attracting Jinns so don't trust them. I'd rather not know the religion of my therapist*

*I am yet to meet Muslim therapist who mixes faith and conventional techniques. Also, Muslim therapists are not BACP accredited so I can't use my insurance. I have gone to a Muslim therapist but she wasn't very observant. I think therapy is like medication if for our physical health the faith of our doctor is irrelevant then for my mental health I don't need a Muslim therapist.*

*I've had two Muslim therapists in the past, I felt that they were judging me on my lifestyle choices and behaviours. I did not feel I could open up to them completely and this had a detrimental effect on my treatment.*

Other reasons were, as before, to do with fears of experiencing bias or prejudice with participants referring to fears of feeling 'judged'. Similarly, a dim view of Muslims' professionalism was cited, with some of those who had experienced counselling in the past claiming a lack of objectivity as a basis for their negative preference.

In the discussion groups, it was noted that "clients have a perception of Muslim counsellors who wear a hijab and those who don't wear a hijab". The focus on such a visible symbol of faith is an instructive one and is perhaps somewhat indicative of how superficial but pervasive perceptions of Muslim counsellors can be.

The reasons given by participants point to various complexities when it comes to addressing cultural competency in mental health services. It is fair to say that the strengths associated with diversity and inclusion in the sector, making services more accessible to those from minority ethnic backgrounds by having counsellors that service users can relate to, can also present drawbacks with shared characteristics being perceived as introducing something 'too familiar' to be objective or unbiased. There is clearly a perception among some young people that counsellors or therapists being of Muslim background might compromise the quality of care received.

Why such perceptions exist is not something that can be answered using this dataset but the point of inquiry presents an opportunity for Muslim professionals working in mental health services to redress. In the Adapted Behavioural Activation manual produced by Mir et al, it is suggested that all therapists, regardless of background, should support discussion about any preconceptions the client may hold and seek to provide reassurance of professionalism and a non-judgemental approach.[186] A perception that Muslim counsellors or therapists' positionality within faith and mental health contexts could compromise their ability to serve a patient's needs is evidently an unhealthy one. And while for many participants the availability of counsellors of Muslim background is the favoured choice, some sceptical voices also prevail that ought not to be ignored.

When testing for a correlation between having experienced counselling and whether an individual would prefer to see a Muslim counsellor or therapist, the correlation coefficient shows a very strong positive correlation, r=0.997. The correlation denotes that among those we consider service users, individuals who have prior experience of counselling or therapy, a stated preference for seeing a Muslim counsellor is highly pronounced. As the explanations offered by participants in this survey suggest, the need to be understood without prejudice or unconscious biases entering into the room are important factors driving their preference.

186 Mir et al., 2015.

# Is it important to you for mental health services to be culturally/faith sensitive?

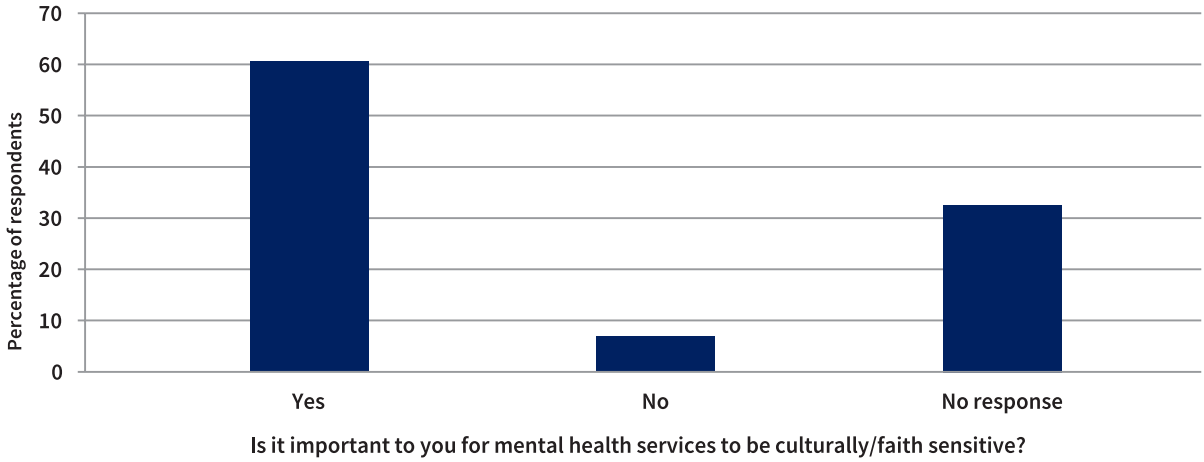
Though the faith background of an individual counsellor or therapist may be considered a matter of personal preference when seeking mental health support, the issue of whether mental health services are culturally or faith sensitive is a question that surpasses individual choice to take into account the nature of an institution providing health services in a diverse society. In much the same way questions are raised about social and health inequalities faced by minority ethnic communities and the composition of institutions that address their needs in specific sectors, such as in housing, education or policing, when it comes to mental health services expectations of diversity and its impact on health outcomes is an important metric for assessing standards in healthcare provision.

In a survey of this nature, with its emphasis on the needs of young British Muslims, exploring how important it is for mental health services to recognise the diverse base of service users helps us understand what service users from minority backgrounds are seeking from mental health services and why.

It should be noted at the outset that the framing of this question was problematic for many participants for whom the presumed conflation of 'culture' and 'faith' was badly conceived. Many participants in their responses criticised the presumption that culture and faith could be coupled in this way. For some, the coupling was read to suggest the terms were considered interchangeable, something they strongly disputed.

Though the question might better have been framed as 'culturally and/or faith sensitive' to clearly distinguish between culture and faith, it remains the case that the racialisation of Muslim communities in contemporary times often renders culture and faith synonymous when considering the Muslim subject. Culture, as deduced from an individual's ethnicity or name, can come to be treated as a proxy for faith with 'Asian culture' equating to 'Muslim traditions' and cultural practices imputed to the religion irrespective of whether an Asian individual identifies with Islam or observes it. The problem is compounded when cultural tropes are carried too far such that any inference to Muslim faith is condensed to a specific, narrow cultural milieu - here, Asian culture becomes the prism through which many different Muslim ethnicities are filtered, regardless of the applicability of the norms and mores of one particular cultural tradition (South Asian) to another (Arab or African Muslims). Notwithstanding the clumsy wording of the question, the nuances evident in distinguishing culture and faith were present in participant responses.

Figure 42. Importance of mental health services being culturally/faith sensitive




Three in five participants, 61%, said it was important to them that mental health services display cultural/faith sensitivity with just 7% saying no, and a third offering no response to the question.

Among those who have experienced counselling, there was a palpable importance attached to cultural/faith sensitivity, with nearly 90% (89.7) stating so, and just under 10% (9.87) saying it was not important. The figures are similarly striking among those who have experienced long bouts of counselling, with over 90% of those having experienced a few or numerous sessions saying it was important services were sensitive to

culture/faith, compared to 9.5% who disagreed. Taking into consideration that those who have experienced counselling are speaking from experience of using mental health services over a period of time, the importance attached to the need for culturally/faith sensitive services is a strong indicator of the quality of care received. This is apparent in the explanations offered to supplement the binary choice.

Reasons given by participants for why they considered culturally/faith sensitive mental health services important ranged from the most common response 'understanding' (35%) and quality of care (23%) to more generic considerations of cultural literacy as a requirement for services in an ethnically diverse society (6.3%). More than a quarter of participants (27%) offered no explanation for why they felt mental health services being culturally/faith sensitive was important.

As with the answers offered in response to the question about preferring a Muslim counsellor, being 'understood' was a primary concern; having culture and faith understood without the need for prior explanation, feeling someone comprehended the appropriateness of remedies in different cultural contexts and bringing one's 'whole self' to therapy were many of the reasons given.

*Culture influences us, therapists need to understand this so they can understand the complexity of peoples struggles*

*In order for mental health services to be fully effective, we need to feel understood, and if services are not culturally/faith sensitive, they fail to build the trust and understanding that people need in order to open up and discuss their problems*

*I don't think most services know what cultural challenges feel like or how to deal and live with them.*

*I feel I have to miss out parts of me, in therapy, because the therapist won't be able to understand. So, I often leave out that side of me which is unhelpful because religion is a massive part of my life so then the therapy can only be useful up to a certain point because I'm having to restrict myself*

*Non-Muslims have to understand some things aren't appropriate in a Muslim household*

*Don't want to be re-traumatised or judged as being inferior for thinking and believing different to the majority group*

*I had counselling through my GP but I don't feel that my psychologist understood the pressure of being sexually abused and suffering with mental health in a Muslim household.*

When it comes to quality of care, participants keenly elaborated on circumstances where lack of sensitivity of culture or faith can limit how effective treatments can be.

*Sometimes they have a pre-conceived opinion when they see a Muslim and assume a lot of our issues are due to our religion. This is very annoying as it's not the help someone could be seeking, sometimes religion is difficult but it is never the reason for my struggles and stress/depression etc. However, they find a way to focus on religion as the issue sometimes*

*Culture/Faith is a big part of how people view struggles and allows several coping options rather than just a one-sided approach which limits your options*

*Support that isn't faith sensitive can do more harm than good. It's important that services have a level of competency to be sensitive to the needs of the whole person, including gender, race, age, religion, sexuality etc*

*For example, if I told my therapist I was struggling with hijab, I wouldn't want them to tell me to just take it off etc*

*I think all services should be sensitive to individual differences and consider wider social factors, like religion and culture, which play a huge role in people's lives. Particularly if these areas are sources of strength and support for people they should be incorporated and thought about. Most mental health services and forms of therapy are based on western principles, as is the research base, which may not be appropriate for a lot of people. I feel services have a duty to not try to fit everyone into the same framework, when peoples experiences and cultural backgrounds are very different, and so could be more effectively helped in different ways*

*It is important for mental health services to see that faith can be a relieving factor for some people and if the person with mental health is open to getting closer to their faith to overcome their issues then faith should be used.*

*It resonates better if mental health services are more aligned to your view of the world*

*There is a need. I had a counsellor for 2 sessions who kept asking me "oh, but in your community you aren't allowed out and be educated". I felt as if I was educating her and felt 10000 times worse when I left. I decided never to go back to her. She was an older German lady.*

Some participants spoke of a creeping bias that comes with services that neglect cultural/faith sensitivity, where being from a minority ethnic/faith group can compound feelings of being marginalised or patronised by the dominant group:

*Not look down on you for believing in God*

*Can't be shamed for having a faith or relying on it to cope*

*It saves me from feeling stupid for believing*

*My culture and religion are part of my life and what I'm used to, so to not respect it would be disrespecting me as a whole*

*Speaking about mental health is hard enough as it is, without having to explain the culture you come from. You also don't want to perpetuate and pander to the negative stereotype about some communities when talking about your issues to professional services, this just deepens the prejudice and misunderstanding against certain communities*

But the bias can work both ways, and for those who said it was not important for services to be sensitive to cultural or faith traditions, a sense of tacit predisposition in service provision if it were so was considered the problem:

*Religion plays a part in some of my struggles*

*Because sometimes the abuse is cultural and that doesn't help*

*Sometimes just want to be listened to instead of preached to*

*I would not want to be treated differently because I wear a hijab*

*Rather just see me as a human being than any of my cultural or religious identifiers - they can be a means of reinforcing stereotypes or expectations or what people 'think' it's like to be a Muslim / Pakistani / other*

Very few participants framed their explanations in unambiguously religious terminology. Only five participants gave explanations that placed an onus on religious teachings as being the reason for the importance attached to culturally/faith sensitive services:

*Islam gives solution to all such problems*

*I like having Islamic support to show prophets and women in Islam who also had mental health problems*

*All advice should be from faith*

*Islamic perspective*

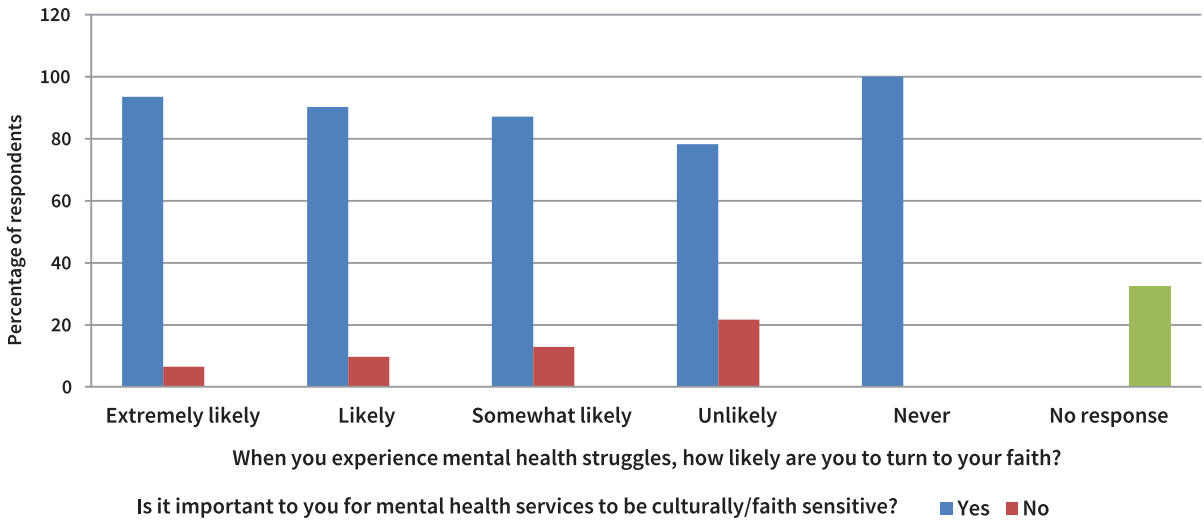
*So the advice can be based on teachings of Quran and sunnah*

The pre-dominance of rationales centred on comprehensibility, care quality and cultural literacy suggest young Muslims are not looking for mental health services to supplant the roles of religious instructors when seeking culturally/faith sensitive services. Indeed, quite the opposite, with very few looking for service provision that evokes religious prescription and a minority expressly rejecting the premise outright. The demand for cultural/faith sensitivity comes from a deep-seated desire for a 'person-centric' approach to be adopted by services such that individuals, whether observant Muslims or not, can feel cared for, catered for, and accommodated within the sector. At the same time, the 'person-centric' approach dictates that being of Muslim background should not predispose counsellors to view individuals solely through the prism of their faith but rather, to understand a person's attachment to their faith, whether strong, weak or somewhere in between, and to value how they see it as important, or not, to their sense of wellbeing and as a source of comfort or strength. What we note in this survey is the strong attachment to faith disclosed by participants and the onus they place on its role in navigating their individual struggles and their expectation their choice is respected and recognised in the support provided by others.

Why the accommodation of religious sensibilities matters can be further examined by looking at the extent to which participants say they are "likely to turn to faith" when experiencing mental health struggles and how important they say it is for mental health services to be inclusive.

Unsurprisingly, those who say they are 'extremely likely' or 'likely' to turn to their faith also indicate a strong desire for services to be culturally/faith sensitive, with those 'somewhat' or 'unlikely' to turn to faith showing lower levels of significance attached to how inclusive services are seen to be. Nevertheless, the majority remain in favour of services being culturally/faith sensitive even if the participants themselves would not in all likelihood turn to their personal faith when dealing with mental health struggles. Interestingly, all those who say they would 'never' turn to faith when experiencing mental health struggles say they feel it is important services are culturally/faith sensitive.

Figure 43: Turning to faith and importance of culturally/faith sensitive services




Of the two participants who offered an explanation as to why, the reasons were to acknowledge difference and to keep a residual attachment to faith even when this is not a recourse chosen whilst experiencing difficulties:

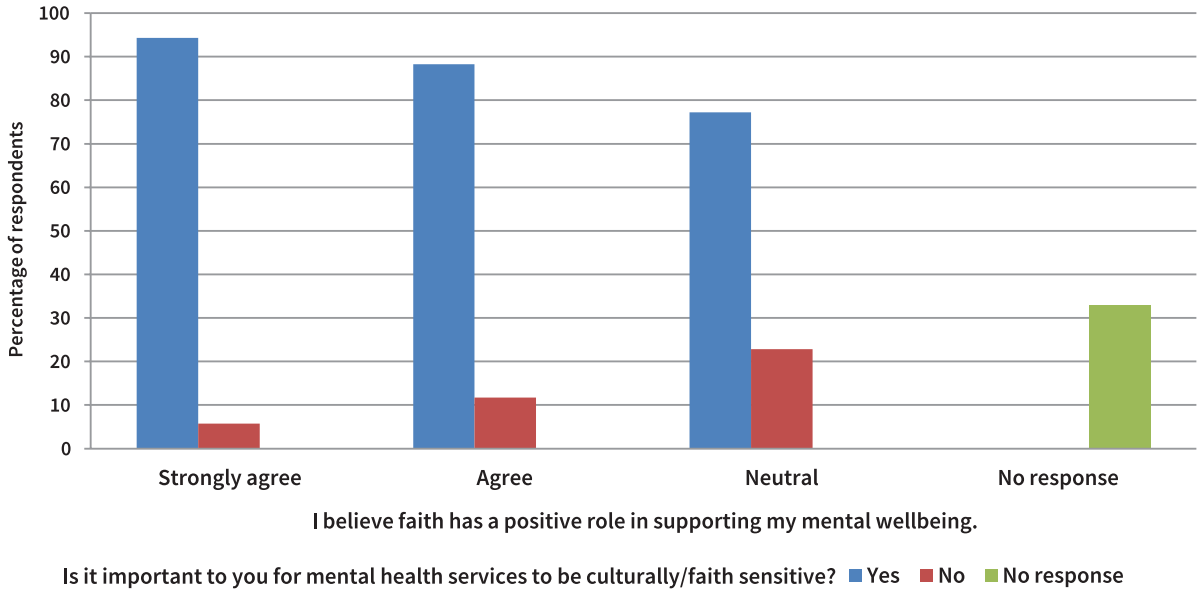
*Everybody should acknowledge peoples differences regardless of who they are*

*As my mental health will weaken my faith and I would like to better myself and faith as I know that will make me a better individual in life*

To reflect on this slightly differently, when looking at the emphasis placed on personal faith as playing a positive role in supporting mental wellbeing and whether it is important for services to be inclusive, those who agree faith plays a positive role are overwhelmingly in favour of services being sensitive to cultural and faith traditions. This is less so for those who stay neutral on the question of faith having a positive role to play though here too, the disposition to inclusive services is in the majority (77%).

In a later section we return to how participants feel faith plays a positive role supporting mental wellbeing. Suffice to say here that the analysis shows a striking positive correlation on the question of whether mental health services should be culturally/faith sensitive with even those who do not themselves identify as observant Muslims, or disclose a reliance on faith when experiencing mental health struggles nonetheless favouring services that are inclusive and respectful of religious beliefs.

Figure 44. Faith as a supportive factor in mental wellbeing and importance of culturally/faith sensitive services




In the statistical test for assessing a correlation between having experienced counselling or therapy and (a) the important attached to mental health services being culturally/faith sensitive (b) believing faith has a positive role in supporting mental wellbeing, the correlation coefficient shows a very strong positive correlation with r=0.997 in both (a) and (b) cases.[187]

The significance of the correlation is not to be underestimated when considering the participants in question are service users. The strength of the correlation denotes the high value attached to receiving mental health care that is commensurate with how these service users view the role of faith in supporting their wellbeing and the cultural/faith sensitivity desired in the care environment in which they articulate their struggles and their needs.

How young Muslims say they use faith and spirituality to support their mental wellbeing is what we turn to next.

187 Correlation is significant at the 0.01 level (2-tailed).

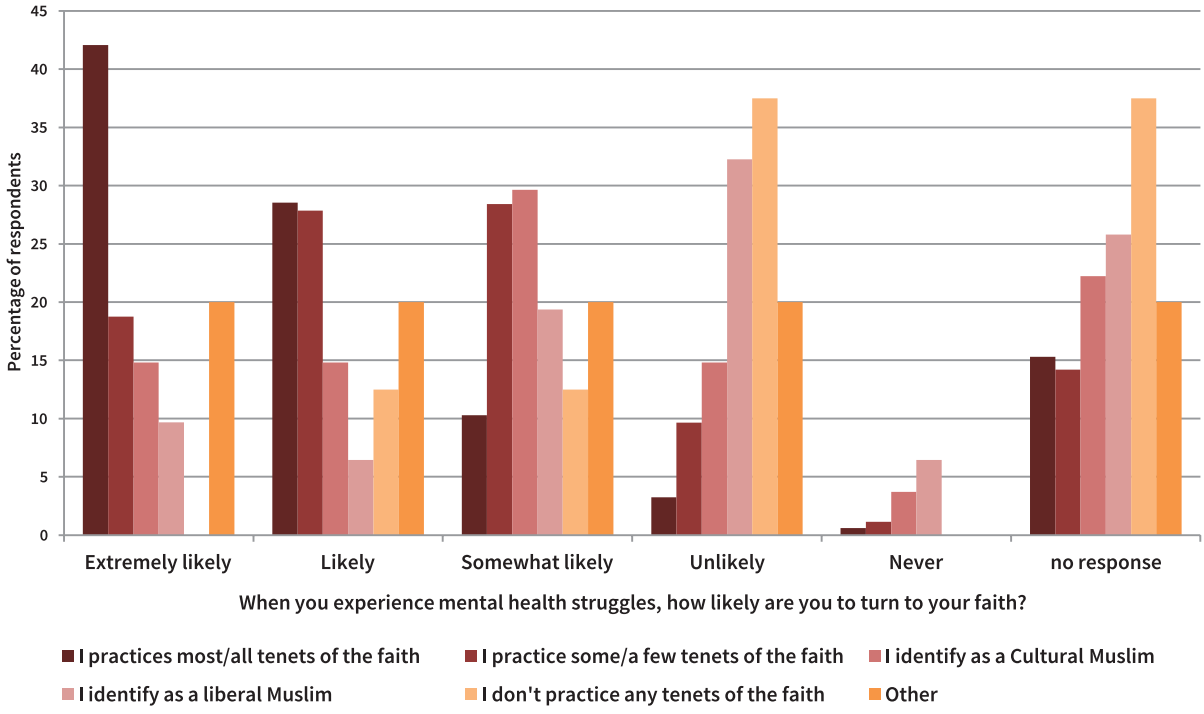
# When you experience mental health struggles, how likely are you to turn to your faith?

For Muslims and people of other religions, faith can be a source of strength when struggling with mental health problems. The use of prayer as a meditative and contemplative device or as a coping mechanism (Maltby et al 1999), as a method of embedding some type of routine into daily life, and the belief in a higher purpose supporting an individual's evaluation of their self-worth and place in the world are all noted for their positive effects on wellbeing and coping with mental health problems. Though studies on the subject of faith or spirituality and mental health are not uniformly positive, with faith also documented as having an adverse impact (Pargament and Raiya, 2007), for example feelings of guilt and shame intensifying conditions such as anxiety or depression, the role of faith is not to be easily dismissed.

As covered in preceding sections, faith as a basis of self-identity is more pronounced among British Muslims than it is in other religious groups, and engaging in some form of religious practice is something the majority of young Muslims say they do at least once a week.[188]

In this survey, young people were asked about the likelihood of their turning to faith when experiencing mental health struggles and to elaborate on their choices. Figure 45 shows the crosstabulation between the likelihood of a participant turning to faith when experiencing struggles and the individual's degree of religious observance.

Figure 45. Turning to faith and level of religious practice




Expectedly, those who say they are extremely likely or likely to turn to faith (42) are those who display high levels of religious observance (practicing all/most or some/few tenets of faith), and 29% of those who say they practice all/most of the tenets of the faith are extremely likely or likely to turn to faith, respectively. While those who are somewhat less observant, practicing some/few of the tenets of the faith, show lukewarm dispositions to turning to faith as 19%, 28% and 28% say they are extremely likely, likely or somewhat likely, respectively. Almost three quarters of those who are mainly observant Muslims (71%) say they would turn to faith, compared to less than half (47%) of those who are less observant. Contrastingly, those who self-identify as less observant, either describing themselves as cultural or liberal Muslims, say they are somewhat likely or unlikely to turn to faith when experiencing mental health struggles.

188 Ipsos Mori - religious practice once a week/ once a month

Cultural Muslims are perhaps more inclined to seek some recourse to faith with 30% and 15% saying they are somewhat likely or unlikely to turn to faith, respectively, compared to 19% and 32% of liberal Muslims who said the same. Cultural Muslims more frequently than liberal Muslims said they would be extremely likely or likely to turn to faith but both cultural Muslims and liberal Muslims were more likely to say they would never turn to faith, compared to all those showing some degree of religious observance. Among those who say they do not practice any of the tenets of faith, the most common response was unlikely, 30%, although equal numbers said they would be likely or somewhat likely, 13% respectively. Far fewer observant Muslims said they would never turn to faith when experiencing struggles, 1% equally among those who practice all/most or some/few tenets of religion compared to cultural and liberal Muslims of whom 4 and 6%, respectively, said they would never turn to faith.

Those who weakly identify with their faith identity are less likely to regard faith as a support when it comes to mental health struggles but the variance in responses reveals that a weak religious attachment does not necessarily equate to the wholesale dismissal of faith as a recourse when undergoing difficulties.

Of those who say they have experienced mental health struggles, a little under two thirds, 61%, say they are extremely likely (31%) or likely (30%) to turn to faith, while 21% say they are somewhat likely and 10% unlikely. Only 1% of those who have experienced mental health struggles said they would never turn to faith.

Among those who have experienced counselling or therapy, the figures are marginally higher than for those who have experienced mental health struggles, with 33% saying they would be extremely likely to turn to faith and 30% saying they would be likely to do so. About a quarter, 24%, are somewhat likely to turn to faith and 11% say they are unlikely to do so. Service users it would seem are more inclined to turn to their faith when experiencing mental health struggles.

For those who have experienced counselling or therapy, when asked to elaborate on their answers, those who say they are extremely likely or likely to turn to faith explained their reasons for doing so principally in terms of having a place to turn to, feelings of peace and serenity that follow with prayer and contemplation, offering prayers asking for help and finding solace in religious teachings that exhort fortitude, patience, and trust in God.

*Talking to Allah. Making Dua helps. 5 prayers a day root me.*

*Prayer and Quran reading helps me feel a sense of peace.*

*I turn to my faith to remind myself of the wider picture and to ask Allah for help.*

*I pray to my Lord and he is my best friend, I can complain, praise, beg, pray to him.*

*I know that I'm not alone, I have Allah and Allah knows what is happening and because everything happens for a reason I'll find a way out. Allah will help me.*

*I like to visit the mosque in times like those. Pray and read. Gives me sense of peace and brief relief. It can be harder to wake up for Fajr (pre-dawn prayer) sometimes but I still try*

*I would feel very low but I would always remind myself everything happens for a reason and it is Allah's plan. The outcome of the whole situation may have stopped me from falling deeper into a bad situation or saving me from one.*

*I reason that my struggles are a test and find the strength to turn to god whether that be in salah (prayer), dua (supplication) or dhikr (chanting remembrance of God)*

*Faith is a safety net that protects the mind with structure and routine*

*It helps and is key to my resilience*

*As talking to God or seeking help from God has put my heart at ease many times.*

*Salah (prayer) helps keep a routine and cleanliness which gives me a purpose*

*It's very hard to just pick up a namaaz (prayer) mat when you feel completely worthless and demotivated but once u do it's like that's the only place you will ever be heard*

*I feel better when I am consistent in my prayers and focus on spending time learning*

Some participants explained why they turned to their faith in times of struggle in terms of the emotive, evaluative and function aspects of mental wellbeing. When it comes to emotional support, participants explained how turning to faith provides them a sense of peace, calm and comfort:

*Praying (salah) really calms me down. When panicking, I'll pray to God to ease my pain/ anxiety.*

*I always pray, put Quran on, do my dhikr and put my trust in Allah. It usually comforts me and soothes me.*

*In the remembrance of Allah, hearts find peace.*

*I pray a lot and that brings me a lot of ease, these issues come from God and only he can heal me.*

*Prayer/remembrance of God are an immediate means of ease from the difficulty. It is comforting to know that He is there, He Knows.*

In terms of functioning, participants referred to faith as a coping mechanism:

*My faith helps me put things into perspective and see things in a different way. It helps me to cope by giving me reassurance and answers to my questions.*

*Prayers when I couldn't sleep*

*Turn to faith as a coping mechanism*

*It's what gives me relief, it's what keeps me going, it's what makes the uncertainty okay.*

For others, faith as a coping mechanism was linked to prevention of serious harm or adverse outcomes:

*I would readily consider suicide and self-harm if I wasn't a Muslim.*

*I had severe depression and attempted suicide. Praying and getting closer to God was what helped me through it*

*God keeps me alive and from committing suicide. I turn to my faith as a deterrent.*

It terms of the evaluative aspect, for some participants faith can provide perspective, the ability to contextualise oneself and one's pain on a wider canvass, of seeing one's life journey in a teleological narrative of human life and its purpose:

*Remembering my purpose in life and following Islamic guidelines*

*My faith keeps me centred and allows me to have hope in God's plan. Knowing you have Allah by your side always without fail bring something comfort and ease to my heart.*

*I have been given a framework to use, and to turn to God. This has only come about recently, previously I did not turn to God and felt hopeless.*

*Prayer and dua and remembering the imams and seeking wasila helps to contextualise pain and grief as a struggle from God necessary for growth*

*Making dua, telling myself what is decreed will happen, Allah knows I can handle this - if Allah thinks I have the strength for it then I do and that helps me get through*

But even those who profess to be extremely likely or likely to turn to faith sometimes need further help and support to enable them to draw on their faith as a resource for recovery:

*Sometimes it helps, sometimes not*

*There are times when I seek comfort within the Qur'an and prayer however there are other times when I am too ashamed of myself and what I am feeling to seek help from Allah*

*I know that my religion is a means to supporting my condition but in the midst of anxiousness I find it hard to rationalise. Many thoughts I cannot separate from reality*

*I seek help and guidance from God, although it's not easy. I try to look at my struggle in a way that includes God as the answer; depending on him gives me some form of explanation and relief from the struggle.*

*I know Allah is the source of all help and assistance but often my mental health difficulties effect my iman.*

Of those who are highly observant of their religious practices, mental health struggles can also present obstacles to the performance of rituals, as some participants described:

*I sometimes blame God and end up turning away from him*

*My faith weakens a lot as a result. I make du'a (supplications) for it to pass but other than this I tend to stop perform extra non-obligatory duties such as performing extra prayers, reading or memorising Qur'an, etc.*

*Hard to focus on faith*

*If Allah put us in this situation turning to him is quite difficult. Rather let nature take its course. Praying etc does nothing to help but talking therapy is good*

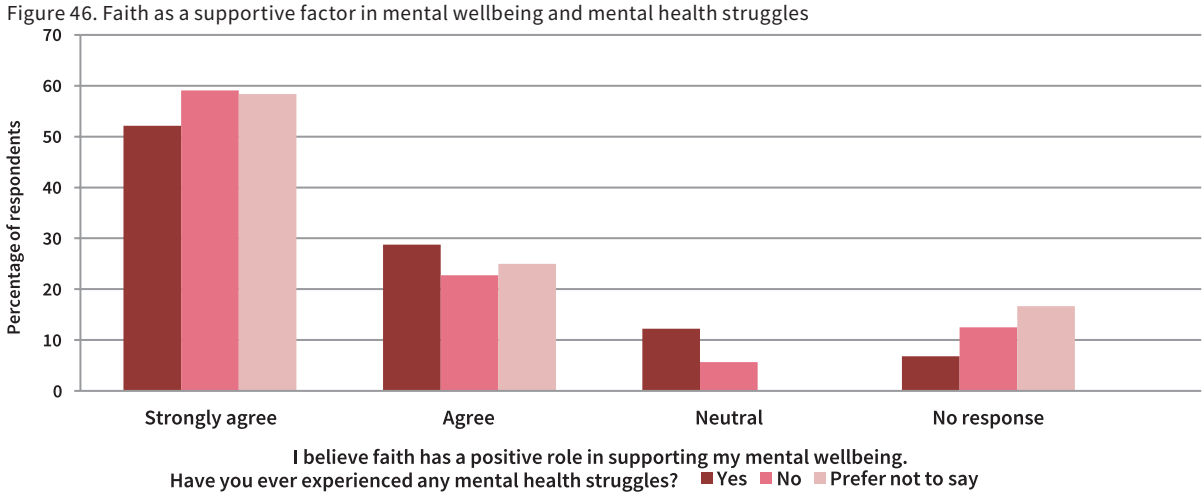
*I sometimes feel less motivated to pray when I am low*

Another participant who otherwise self-describes as religious observant noted that they would never turn to faith because it offers "nothing practical" when experiencing mental health difficulties. The concept of 'negative religious coping' appears to bear relevance here, with the responses above suggesting a focus on being punished, despairing of God's mercy and finding little solace in usual practices associated with 'positive religious coping', such as prayers and firm belief in a merciful God.

The reasons for turning to faith when experiencing mental health difficulties are many and varied though most given in the survey conform to what is known of why individuals take recourse to faith as resilience and a source of support when experiencing difficulties; emotional strength, coping strategies and offering a sense of purpose and design that can help contextualise feelings that can otherwise seem overwhelming. For some, turning to faith is not a panacea even though they may profess to being more likely to consider it a benign route when seeking help. Struggling to make sense of what it happening and why, and lacking the motivation to perform religious worship can compound already fraught emotions. What we can discern from the analysis is that turning to faith is a valuable outlet for many young Muslims who have battled mental health struggles. And for those who have undergone counselling to help them with their problems, faith plays a multifaceted role in helping them steer a course out of their travails.

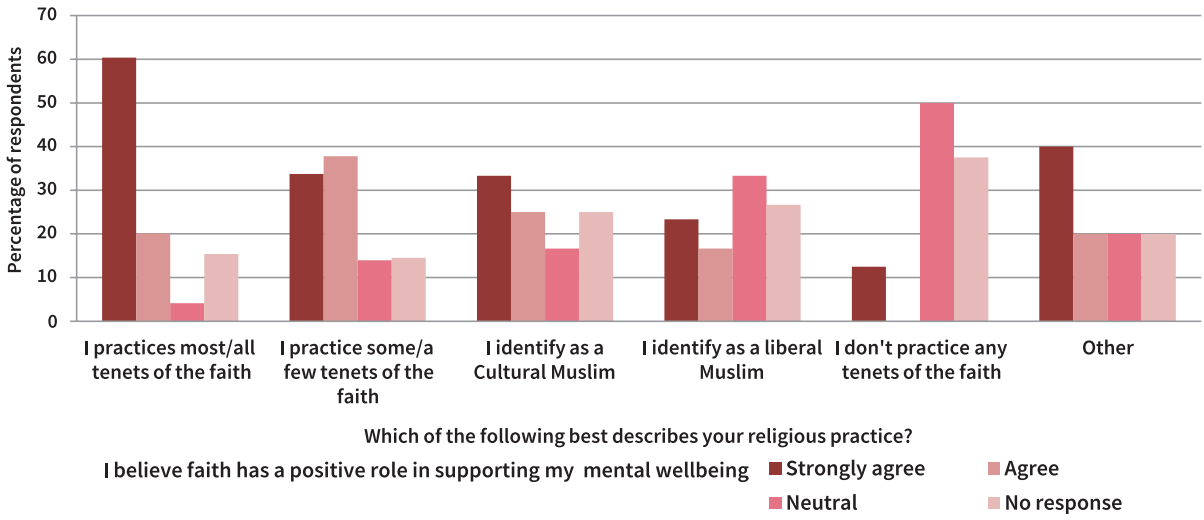
Indeed, when asked whether they felt faith has a positive role in supporting their mental wellbeing, the majority of participants strongly agreed or agreed that it did, 38.5 and 20% respectively, with 8% saying neutral and almost a third, 32.5% offering no response. Those saying they disagreed or strongly disagreed were negligible, 1% disagreed and 0.3% strongly disagreed.

Figure 46. Faith as a supportive factor in mental wellbeing and mental health struggles




Among those who have experienced mental health struggles, there is a high tendency to regard the role of faith positively with over half saying they strongly agree and nearly a third saying they agree that faith has a positive role in supporting wellbeing, 52% and 29%, respectively. Among those who haven't experienced any struggles or prefer not to say, similarly, the majority view the role of faith positively, 59% and 23% and 58% and 25%, respectively, say they strongly agree or agree.

Figure 47. Faith as a supportive factor in mental wellbeing and religious practice




Those who are religiously observant are more likely to view the role of faith positively than those who are less so, although even among those who say they identify as cultural or liberal Muslims and those who profess to not practising any of the tenets of religion, participants either view the role of faith positively or remain neutral. Markedly, they do not disagree.

The correlation coefficient between experiencing mental health struggles and a belief that faith has a positive role in supporting mental wellbeing bears out the strong tendency among participants to view faith as a benevolent tool with a statistically significant association; r=0.91.[189]

Looking at the correlation coefficient between turning to faith when experiencing mental health struggles and the belief that faith has a positive role in supporting mental wellbeing, we find a further strong correlation of r=1.0.[190] For young Muslims in our survey, faith clearly matters when it comes to conceptualising good mental wellbeing and when navigating bouts where struggles manifest themselves.

To explore why faith is seen as playing a positive role, we turn to questions which asked participants to describe situations or circumstances in which faith has helped them when faced with a mental health struggle.

189 Correlation is significant at the 0.05 level (2-tailed).
190 Correlation is significant at the 0.01 level (2-tailed).

# Can you share an example of when your faith has helped you with a mental health struggle?

Two thirds of participants shared examples of when faith had helped with a mental health struggle, 67%. Half of these were from participants who have experienced counselling or therapy. 63 participants (13%) gave no further details either writing “not applicable” or “not sure” and “can’t think of an example” or similar. Three participants wrote “prefer not to say” and around a third (32.6%) skipped the question entirely.

Of the total who gave a response, nearly nine in ten (88%) were those who strongly agreed or agreed faith has a positive role to play in supporting mental wellbeing, 58 and 30% respectively. Under 10% were examples offered by those who were neutral on whether faith has a positive role to play, and a minority from those who disagreed or disagreed strongly about faith having a positive role to play, less than one% respectively. Admittedly, it is more probable that those who feel faith has a positive role to play would be willing and able to share examples exemplifying how and why this is the case than those who said otherwise. For those who disagreed or disagree strongly, a later question sought to offer the opportunity to relate examples when faith did not help with a mental health struggle.

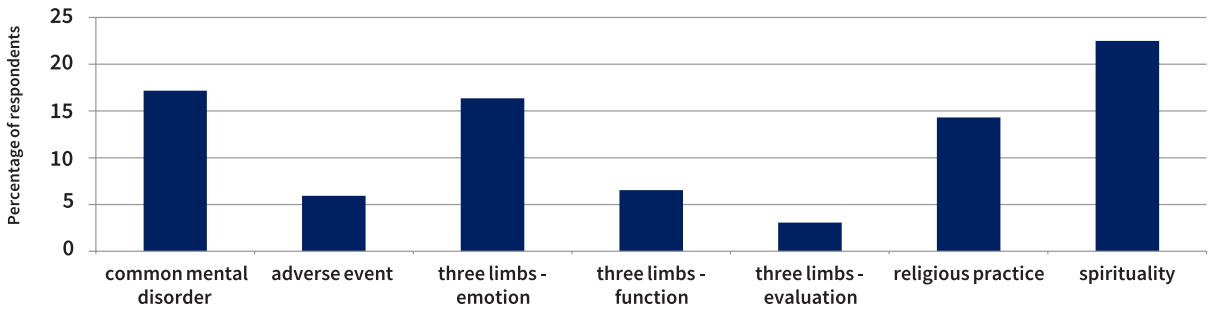
In analysing the responses, codes were applied to differentiate between examples that:

i. *referenced a common mental disorder or serious mental illness (e.g., self-harm)*
ii. *referenced a trigger or adverse event*
iii. *referenced the three limbs of wellbeing: emotion, function, evaluation*
iv. *referenced specific forms of religious practice*
v. *referenced generic beliefs/spirituality*

Four responses were negative, with participants stating “It didn’t”, “It hasn’t really”, “It generally doesn’t” and “I don’t usually turn to faith for these”. Of those who offered examples, the distribution across the five stated categories is as shown in the graph below.

Looking at each category in turn, 17% of responses referenced some form of common mental disorder with a large number of participants referring to conditions such as anxiety, stress, depression, bipolar disorder, post-traumatic stress disorder and OCD. Some referred to more serious illnesses, such as self-harm and suicide, when detailing instances when faith had helped with their struggles. Suicide featured quite prominently in this category. Suicide, or rather the prevention thereof, was a key contribution of faith when it comes to mental health struggles.

Figure 48. When faith has helped with a mental health struggle by coded category




*excludes no response, negative and prefer not to say

Participants referred to situations where faith had helped pulled them back from the brink, or where it had offered a route out of prevailing dark thoughts:

*General faith in God keeps me going, praying gives me hope for the future. Thinking of God helps when I feel suicidal*

*[Qur'anic verses] 2:285-286 for controlling suicidal thoughts*

*Having suicidal thoughts can create a huge dip in how strong you are in your faith. But every time I've thought of all of the prophets lives I remember how they struggled so much yet kept so firm in their belief. It helps me not look into those thoughts further*

*When I have been suicidal, I know not to do anything because it's a sinful thing to do.*

*I stopped at the 12th Paracetamol*

*It's prevented me taking my life and helped me make sense of trauma and the pain of life*

*Faith has always stopped me from giving up and taking my life. Faith has always encouraged me to help those around me regardless of anything. I went through an intense bout of depression and had made my mind up to overdose, but the only thought that stopped me was "What will I say before Allah?". He loves us more than our mothers so then why should I not trust Him.*

*When I went through mental trauma and extreme anxiety and depression, I tried to kill myself many times. After so many attempts, I read the Qur'an and found peace through the truth. My mistakes do not define me, my Deen does. If Allah is All Forgiving, who am I to not forgive myself? SubhanAllah.*

Depression and other disorders also featured significantly as struggles where faith has helped:

*Was going through diagnosed depression, Islam provided me with comfort and reassurance*

*Prayer during times where I suffered from OCD*

*The last time I had an episode of anxiety and depression I started praying again and listening to a podcast which would remind me the real purpose of life. The love for Allah and the closeness to Him would often give me the strength to carry on*

*I'm currently struggling with PTSD and prayer really helps*

*During my depression I started praying 5 times and praying tahajjud (night prayers) and doing dhikr and I felt like it is what helped me to recover*

*When I was very depressed, not attending school, always crying etc. my faith gave me the strength to keep going, stay studying even if I didn't have the courage to attend school. It has also really helped me with dealing with disturbing thoughts because faith-based explanations of this (for example them being the whisperings of Shaitan [devil]) have really helped me to not spiral into a depressive episode because I believe having these thoughts makes me evil*

Adverse events were cited in 7% of examples, with trauma relating to divorce, bereavement, post-natal depression, terminal illness in a relative and abuse triggering different mental health problems from which participants found some relief in faith.

In the three limbs of wellbeing, emotion outweighed function and evaluation, with participants describing the benevolence of faith in terms of providing "comfort", "hope", "peace" and a sense of "calm" amid turbulence. Faith offering a "sense of purpose" was a common feature in examples within the evaluation limb and for function, participants spoke of faith both in terms of enabling function, helping them to cope with their circumstances, and also of serving a function: offering an avenue for talking about their struggles; in prayer to God. Being able to "offload" their tribulations through talking, feeling there is someone listening and treating prayer as a form of "talking therapy" were ways in which participants described faith as helping with mental health struggles. If when it comes to mental wellbeing and mental health struggles, functionality is debilitated by a sense of loneliness and solitude, faith providing an outlet for expressing one's pain is a way in which functionality is restored.

Prayer and spirituality were differentiated in the analysis, with the former expressly referencing prayer as an act, sometime elaborating on specific prayers from the Qur'an, while the latter usually denoted a range of spiritual beliefs. Spirituality took on many different forms, with participants referring to beliefs on predestination and fate - notions that whatever is decreed by God will come to pass and one must bear it patiently; the virtues of patience and fortitude in Islam - knowing that life is beset by trials; remembering that "after hardship there comes ease" - verses from the Qur'an from which Muslims derive solace in times of difficulty; and drawing comfort in the fact that "God does not burden a soul with a load greater than it can bear". Belief in an afterlife and being able to situate their struggles in a temporaneous context as well as periods in history which inspire forbearance, such as Prophet Muhammad's "year of sorrow" and the challenges faced by earlier prophets as recounted in the Qur'an, were other ways in which spirituality helped when faced with struggles:

*Hearing stories of pious Muslims who suffered through trials and still kept a positive opinion about Allah.*

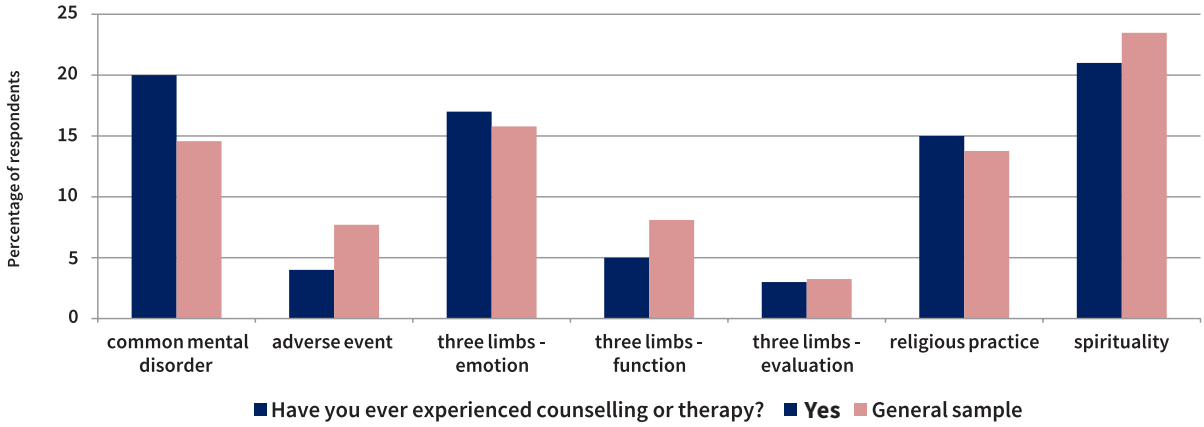
*Learning about the Prophet's struggle etc.*

*Quran has stories and struggles of the prophets with solutions to learn from.*

*A sense of knowing this is all temporary and everything will get better. Looking at the Prophets as examples really helped*

Comparing responses among those who have experienced counselling or therapy with the overall sample, we find some minor variation in the emphases placed on how faith has helped when faced with difficulties.

Figure 49. When faith has helped with a mental health struggle, service users compared to general sample




*excludes invalid and no response

In the sample, those participants who had experienced counselling were more likely to refer to faith having helped by sharing examples referencing common mental disorders or forms of self-harm, and to place a greater emphasis on faith having helped in relation to emotion. Service users were also more likely to refer to specific forms of religious practice than generic types of spirituality, in contrast to the general sample. But in both cases, for service users and others, spiritual beliefs were the most common examples shared of how faith has helped with mental health struggles.

Examples shared under common mental disorders by service users included:

*At a time when I didn't want to live, it made me eat (to look after my body as a gift or trust from God), it gave me discipline with the 5 prayers and quitting substances. It told me to think the best of others which helped with crippling anxiety. It told me to help others which made me feel useful. It gave me comfort and strength when no one else was there.*

*Overcoming social anxiety and shyness. I read about how it is okay to be the reserved member of a group and many of Sheikh Hamza Yusuf's lectures where he speaks about the beauty of this characteristic. It made me realise that it wasn't actually a problem or debilitating but something I should embrace*

*Unemployed for two years severely depressed, salah helped me get out of the depression*

*My bipolar during Ramadan*

*Prayer had helped with my depression. My depression used to be severe, but now it's mild and I'm overall less negative*

*Made dua daily when went through a slight period of depression few years back and it helped*

Emotional support was among the principal ways faith was seen to help with problems for those who have undergone counselling or therapy. Participants referred variously to feelings of "hope", "peace", "calm", "contentment", "ease" "comfort" and "control" and seen in some of the examples shown below:

*I struggle with an addiction till this day, and feel guilty every time I go back. But when I pray my esha salah (late night prayer), read surah mulk and create a relationship with Allah, I ask him to help me and he does. I feel as though my faith has given me hope and has allowed me to remember how merciful and forgiving Allah is instead of fearing his punishment all the time. I used to fear Allah more than I loved him, but after suffering from mental health issues it's taken me back to discover my faith in an unimaginable way. I now love Allah and think of his mercy and love more than his punishment to help me get through my mental health issues. It makes me feel less alone and that Allah understands what I'm going through.*

*In terms of hope, dua, knowing who your lord is, and that with hardship comes ease.*

*Sura 93 is my favourite. It provides me with much comfort.*[191]

*It's kept me grounded and given me hope*

*Gave me contentment and helped me forgive my abusers*

*Acts as a source of comfort when feeling lost and alone- can pray, know that Allah is watching over us all. Praying for change gives strength to work harder towards goals*

Prayer was the most common religious practice referred to in the examples. The five daily prayers were frequently cited but also particular prayers whether specific verses of the Qur'an that resonated with the individual, or general prayers seeking help and strength through the struggles.

*Sometimes turning to certain ayahs from help*

*Finding ayahs that resonated with me and Allah answering specific prayers*

*When I am upset during a struggle, I feel my bond with God, especially through prayer Just praying and leaving it to God*

Prayer also serves to embolden the three limbs, particularly emotion, with participants describing the cathartic effects of prayer as offering a sense of "peace", "comfort" and "connection" - to the self and to God:

*Praying tahajjud - late night prayers has always given me that inner peace because I feel like I have given my problems to Allah.*

*Every day anxiety at work would make me listen to more Islamic lectures and try keep on top with my namaaz not only did it make me feel slightly better but gave me a routine and something to look forward to every time I waited for the next namaaz*

*When I had no one to talk to I would talk to God*

*I was going through a very difficult time in my life for close to 6 months (sometimes I still get those feelings/memories), faith had allowed me to turn to Allah and pour my heart out, ask for forgiveness from Allah, after turning to Allah,*

*I would usually feel much better/numb to the feelings of the mental struggle. I feel without faith, I may have got involved in the wrong crowds and find the wrong outlets to deal with stress such as alcohol or drugs, without that and just turning to Allah, reading Qur'an, doing Dhikr has helped me a great deal more than what other outlets would've done. I feel like*

*drugs/alcohol just numb the pain you go through but do not allow you to deal with your problems head on whereas prayer enables you to deal with it, speak to Allah about it. Go through all the emotions and slowly help with your mental health struggle. Nothing is impossible for Allah, He created us so surely he would be able to turn us from a place of despair and struggle to a place of happiness/content.*

191 Surah ad-Duha.

Service users also offered instances where blended approaches had been adopted, with both prayer and mental health treatment referenced in examples:

> *Prayer in conjunction with an actual therapy session where we discussed other mindfulness exercises, helped*

> *Praying gives you hope psychology but didn't solve it alone.*

What we can say about the positive role of faith is that individuals derive from it a variety of supportive instruments. This can be specifically related to types of self-harm, such as suicide, where religious edicts serve as a protective barrier and help refrain from acts of harm, or it can relate to mental health conditions, such as depression and anxiety, where prayer is seen to help with recovery or seen simply as an outlet for the articulation of troubles to a listening God. It can be related to a state of being, where faith provides necessary emotional support, mechanisms for coping, or giving a sense of direction and purpose, such that individuals can persist with their lives and not give in to the weight of mental health struggles. It can take the form of daily ritual practice, such as daily prayers or frequent recitation of Qur'an, or it can be in the form of a set of spiritual beliefs which though not actualised in ritual worship nonetheless provide a framework for situating one's struggles in navigable contexts and offering hope of working through them. Beliefs such as predetermined fate and ease following hardship offer individuals a sense of fixity, enabling both the acknowledgement of the struggle as a period in one's life but also being able to see past it to a period when ease will prevail and the struggle is overcome. Belief in a proportionate burden to one's capability to withstand it, again, allows individuals to acknowledge the hardship as well as contextualise it so that, rather than be overwhelmed by the struggle, it can be approached as something within the capability of the self to resolve. Stories that inspire forbearance are another example of how spiritual beliefs can help individuals, by positioning their own trials in a historical context that encapsulates the trials of others, thus enabling them to seek comfort through contextualisation and inspiration from stories taken from the lives of pious ancestors.

Taking together the quantitative and qualitative analysis of participants' responses to questions on the importance of mental health services being culturally/faith sensitive, the positive role of faith when it comes to mental health struggles and the ways in which faith is seen to help when experiencing struggles, it seems clear why there are strong associations between faith and spirituality and good mental health. Qualitative findings show that faith and spirituality can make a demonstrable difference to how individuals deal with their mental health struggles and for the participants in this survey, having mental health services that acknowledge and cater for this fact is something they value greatly.

The examples provided of how faith has helped give further insights into why participants reveal a preference to see a Muslim counsellor or therapist and why a strong onus is placed on the culture and faith sensitivity of mental health services. The question of preference is perhaps a matter of personal choice but the wider issue sensitivity in mental health service provision points to a deeper issue: religious literacy. Knowing how faith can help young Muslims to deal with mental health struggles requires a level of religious literacy that can support service providers to identify and integrate the positive role faith can play into treatment methods for Muslim service users.

This is not to say that there are no dilemmas that pertain to the desire for a more inclusive service. As seen in a preceding section, there are examples where participants have clearly denoted times that faith or culture has been an obstruction rather than an aid to their mental health problems. Indeed, the survey does not purport to suggest the broadening of the repertoire of mental health support to involve religion does not present drawbacks. As we see in the next section, which explores examples of when faith has not helped with mental health struggles, the aspiration for mental health services to be more attentive to the role of faith and the ways in which it can help individuals of Muslim background requires nuanced handling and a more thorough understanding of complex inner and outer dynamics.

# Can you share an example of when your faith hasn't helped you with a mental health struggle?

Two thirds (66%) offered a response to the question of which just over half, 52%, were valid responses . The other less than half comprised responses that were either misplaced, with participants variously saying faith had "never not helped" (8%) or not applicable (40%) with some participants stating an example was not readily recollected. A third of the sample left responses blank.

In analysing the responses, the same codes were applied as with the preceding question to differentiate between examples that:

*i. referenced a common mental disorder or serious mental illness (e.g., self-harm)*

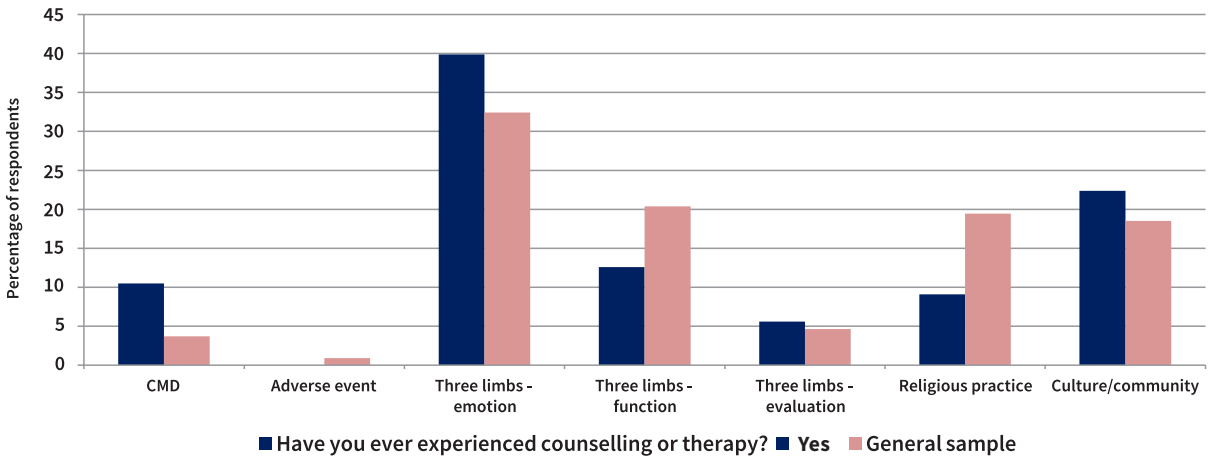
*ii. referenced a trigger or adverse event*

*iii. referenced the three limbs of wellbeing: emotion, function, evaluation*

*iv. referenced specific forms of religious practice*

*v. referenced generic beliefs/spirituality*

Figure 50. When faith has not helped with a mental health struggle, service users compared to general sample




*excludes invalid and no response

The graph above shows the distribution of responses comparing those who have experienced mental health counselling or therapy with the general sample. What is notable in the responses to this question is that the category 'generic beliefs/spirituality' almost exclusively referred to practices within Muslim communities or derived from cultural traditions rather than beliefs associated with Islam. The category is labelled 'culture/community' in the graph to distinguish the fact that no examples offered by participants referred to Islamic traditions with criticisms directed at practices within communities or cultural traditions.

Service users more than the general sample referred to common mental disorders or serious illness, such as acts of self-harm. Examples shared of when faith had not helped referred mainly to depression:

*Depression - reading Quran didn't 'cure it'*

*Depression isn't curable by praying more*

*During times of deep depression when I feel hopeless, despite my own efforts to be motivated etc, when there seems to be no fruit of my labour, those are the times when faith isn't as much of an option in my mind; it's in those times that I can't automatically use my faith to feel better, unfortunately*

Under abusive behaviours or serious illness, the role of faith was seen as not being a sufficiently useful deterrent with users referring to lapses into "drug abuse" and "attempting suicide". The latter is in contrast to responses to the previous question, where faith served as a strong curb against contemplating suicide. In the case of self-harm, participants referred to discouragement arising from "not feeling connected" to religion or failing to find adequate support from religious leaders. The unlikelihood of young people turning to religious leaders for help indicates the importance of the availability of faith sensitive support in mainstream services particularly where the need for help is connected to support to draw on faith or reinterpret ideas linked to 'negative religious coping':

*Other people were feeling more religious in Ramadan and I felt excluded because I would self-harm and not feel connected to the religion like they did. I now fear Ramadan because of my mental health struggles during it and have to put in small actions a few months beforehand to make sure I don't fall into depression again.*

*When I've tried to self-harm, or ask for support I feel left to my own devices as no religious leader is equipped to deal with my issues. Also, when I feel disillusioned it's hard to pray. Muslim doctors can't even give basic advice on lithium and Ramadan.*

No service user mentioned an example involving an adverse event or a traumatic episode though in the general sample sexual abuse was an example given where faith had not helped an individual. No further explanation is offered in the response and further inquiry into why this was the case is not possible on the limited information provided.

Of the three limbs, emotion and evaluation were the most common categories when examining the examples. Notably, emotions referring to "guilt" or to faith providing "no comfort" were the most frequently cited. Participants spoke of guilt both as self-induced, where their faith evoked feelings of blame and culpability, and as externally directed, where other people provoked feelings of shame or censure by passing judgement on personal beliefs and religious observance. Examples of how faith induced feelings of guilt include:

*Feelings of guilt for not being grateful enough*

*Guilt from doing sins*

*Guiltiness perpetuates negative thoughts*

*With suicide, I often feel as though I am to blame and will be condemned to hell of I ever did it, when I have struggled a lot with my mental health and don't feel like I would deserve hell for it. Allah is the most merciful and compassionate but sometimes I struggle to get my head round it.*

*Sometimes I just feel so ungrateful and disconnected*

*When I've been so depressed that I can't motivate myself to carry out all religious practises and I feel guilty and so I get more demotivated and begin to despair*

*Guilt and shame that I'm far away from God makes me feel despair*

*Whenever I hate myself even more for not being a good Muslim*

Other examples spoke of the guilt being externally directed, with individuals made to feel like "lesser" Muslims when judged by others who would see their mental health struggles as emanating from "weak faith":

*Being told I deserve everything that's happening to me because I'm not a good practising Muslim*

*When I've shared with my husband and he's told me it's because I don't have enough faith or read enough Quran. This is something I've heard a lot*

*When parents believe mental health, problems are a sign of weak faith*

*Some people who aren't aware of mental health struggles would say that one isn't faithful enough and that is why they experience these struggles.*

If instances when faith had helped were related to positive emotions derived from feelings of comfort and a sense of calm or peace that prevails from putting one's trust in God, the opposite is seen in the examples where participants revealed how faith did not help. Responses reveal edicts to "have patience" wear thin, with participants also showing a weariness of prayer: many explained faith has not helped because "prayers have not been answered". Some responses display the nuance of managing expectations when it comes to seeking comfort through faith via prayer and feeling despondent at outcomes that have not altered the status quo, with several participants noting the desire for "immediate results" and the frustration at not getting them. For others, prayers not being "heard" was a common refrain, a sense that one's invocations went unacknowledged thus worsening the emotional state. The responses are indicative of the tension between observing familiar Muslim responses to periods of difficulty: exercising patience or seeking comfort through prayer, and feeling despair at unsatisfactory outcomes.

Similarly, in the limb on function, we see that faith as a coping mechanism encounters difficulty when a seeming dissonance arises between reliance and resolution:

*Sometimes faith isn't always enough to stop making me feel anxious. I struggle to just tell myself leave it to faith. I wish I was better at it. Instead of trying to control everything and not wanting even the slightest thing to go wrong.*

*Because Allah obviously does not communicate to us like a therapist would it's sometimes hard not to have an immediate answer*

*In the long term when my episode of anxiety and depression is over and I stop practicing my faith as much, I feel like the beneficial effects haven't lasted in a way that I can just avoid falling back into depression. It doesn't automatically change my mindset for the next time I feel low*

*Insecurity of body issues- takes a journey of trust with Allah*

The practicality of faith as an aid is another aspect of when it is seen not to help. The examples shed interesting light on the expectation of how faith could help and the feelings evoked by situations where these expectations have not been met:

*Practicality but that's a given*

*Not very practical when I feel suicidal or when I need immediate help.*

*When I've needed practical steps and advice in relation to a specific issue/problem*

*I guess in the moment when I am having a panic/anxiety attack I can't just put on the Qur'an or go pray I need to breathe or something*

Those who have experienced counselling or therapy were more likely than the general sample to impart examples which relate to the evaluation limb; of how optimistic individuals feel about themselves, their lives etc. Here, we see that faith is seen to enhance a state of confusion, leaving individuals struggling to make sense of their situation or circumstances:

*This sounds bad but sometimes I feel like Islam's answer to struggles is 'to be patient' and 'everything happens for a reason', 'God will take care of you'. Now I'm not saying that's not true because they are but sometimes when you're struggling with mental health, you can't think logically and turning to faith and the only answer you see are be patient or the others I said, it doesn't help and often makes me feel worse. It's hard to see past your own darkness, so how can you have faith and think everything will be okay when it's not, and you can't help but blame God (whether that's the shaitan talking I don't know but it's how I feel sometimes and often makes my struggles worse)*

*Sometimes doesn't make sense Almost waiting for a response or being unsatisfied with the response, but not realising that Allah plans in different ways that we do not know*

*Has been difficult at times to believe in all loving and merciful God when it seems as if the struggles are too difficult to comprehend*

Fewer service users referenced examples in the category on religious practice although those who did provide details that unveil an important distinction between religious practice in the normative sense, abiding by orthodox codes on conduct and practice and how these can sometimes be the source of difficulty, and practice as "weaponised religion", where codes of conduct or morality are thrust upon an individual and any deviation or shortcoming seen as cause to blame them for the difficulties they experience.

Cases where normative beliefs were seen to affect mental health in a negative way were:

*Putting on hijab and it causing panic attacks*

*My sexual orientation has been a source of my mental health struggles, my actions as a bisexual male being deemed haraam by most mainstream Muslims has been extremely difficult for me*

*Making wudu (ablution) whilst having OCD managing cleaning and whispers from shaytaan*

Examples were given of where religion has been interpreted in ways that seek to enforce conformity and which only cause struggles to become more pronounced:

*When my family use it to cover abuse. Or when I'm made to pray and told how important it is to cover things up. I love praying but heavily dislike my family talking about religion*

*'If you pray hard enough it will go away' leaves you feeling more inadequate or not worthy enough for God to save you from your troubles, that he gave you. It's toxic*

*A believer doesn't get sad, as that means he hasn't put trust in Allah, this was something I read when looking for help*

*Prayer and faith in the Almighty is so important but being forced to go pray, pray, pray, doesn't help - I feel you lose that connection and initial intention*

*Parents have a view that a Muslim is never depressed*

*Being stigmatized or told need to pray more*

*Lots of times, following a bereavement and everyone said to just pray and it'll all be better, hearing in a mosque that depression isn't mental health it's lack of emaan*

In the fifth category, participants did not allude to spiritual beliefs but to beliefs and behaviours they found in communities which they conceived as hindering any benign effect of faith on mental health struggles. The principal sources of contention were "culture" and "community". Culture in the context of this survey is to be largely understood as South Asian given the demographic in the sample, and it goes without saying that this cannot be generalised for other Muslim ethnicities which are not adequately represented in the sample. In this category, participants reflected on attitudes and behaviours which they have witnessed or experienced which have diminished the role of faith in helping with mental health struggles, although admittedly some do draw a distinction between the religion and people or communities who profess to adhere to it. Responses reveal the effect stigma and mental health illiteracy in Muslim communities can have on those who seek support from within their cultural and community milieu:

*It's not faith it's culture. Fellow Muslims have always caused me to feel ostracised. That's challenged myself to stay true to my faith and in general left me feeling low.*

*When being told by other Muslims certain thing she to do as if that will solve all my stresses and anxiety and depression. But that not necessarily faith that hasn't helped it's people .*

*Cultural stigma and taboo*

*Community stigma and taboo*

*Well it is not that faith has no helped me but rather the so call people who represent the faith who will readily use Islam as a tool to oppress to be able to achieve their own agenda or goal. It is those people that make Islam look ugly.*

*Muslims make it difficult, not Islam*

*I think people around me rather than listening to what I was saying resorted to praying and that wasn't helpful. I needed people to listen and understand. The worst thing a person can advise at that time is 'Allah will make it better for you' and I feel like this is used as an excuse to do nothing. It's perhaps not an issue with the faith directly but with other believers who may be confused*

*It's not necessarily my faith that didn't help me but rather the attitude and behaviour of others who claim to be helping in the name of faith*

*When I was really struggling with my mental health (6 years ago), people would tell me to pray more, get Ruqya [prayer modules] done etc. At the time, I was in need of medical intervention (therapy), hence none of the advice people were giving me would help.*

The conflation of culture and religion was a topic also broached in the discussion groups during the conference with attendees keen to draw a distinction between Muslim identity and cultural identity. The issue was broadened to encapsulate the diverse ethnic groups that make up British Muslim communities, with attendees noting Muslim communities, emphasising the plurality of communities. A worthy observation also brought up during the discussion was the homogenisation of groups within the statutory sector with ethnic and religious differences too easily eclipsed by elementary categories that privilege singular characteristics rather than deal with intersectional identities; ethnic, religious, gender, age etc. While participants eagerly sought to separate faith from culture, as well as faith from faith community (i.e., Muslims), identification of Muslims qua Muslims in the statutory sector can reinforce some of the conflations that perpetuate within communities.

A few responses referred to the greater community, not focussing on Muslims but wider British society, in which the perceptions of the Islamic faith and prejudice against Muslims lay at the root of why faith was not seen as helping with mental health struggles:

*Wearing a hijab can be a source of anxiety and feeling worried about Islamophobia you may face; it isn't that faith hasn't helped me but more external factors and discrimination have cause aspects of my faith to feel like they may place me in danger*

*Institutional racism and systematic oppression*

*Burden of responsibility of standing up to oppression*

*Faith has been used against me and my beliefs have been manipulated to oppress me. Also, extremism distorting and polarising the Muslim community. Also feeling defensive and misunderstood in wider British society. Feeling visually different and the day-to-day struggle of that*

In the discussion groups the issue of "microaggressions, infringement of dignity, [and] use of discretion to their bias" was also raised with concern attached to the ramifications of the wider context in which Muslims are viewed in society filtering into clinicians' approach to Muslim service users. Those working in the mental health sector are not impervious to the biases prevalent against Muslims in society, and the likely impact of this on Muslims accessing services is a pertinent area of inquiry particularly in the context of tackling "institutional racism". Examples of such bias is apparent in preceding sections, particularly in the reasons offered by participants for preferring to see a Muslim counsellor or therapist. Moreover, latent in the responses above detailing discrimination, distortion and the "burden of responsibility" that comes with being a Muslim in contemporary Britain, is the challenge presented to carrying these burdens into a counselling session where the culture of the client may be under scrutiny but not that of the clinician. In the discussion group, a point was raised on the importance of "asking the right questions, setting the tone of who you're working with by asking questions and not making assumptions." While the interjection was intended as advice for clinicians in their approach to clients, we would argue that asking questions and challenging assumptions is sound reflexive advice clinicians ought to apply to themselves too if they are to challenge their own (un)conscious biases.

An important dissonance in this category between responses to this question and those to the preceding question, of where faith has helped with a mental health struggle, is the contrast in notions of "community". In cases where faith was acknowledged as helping with a mental health struggle, the sense of community was largely constructed in historical terms - Prophet Muhammad and early ancestors serving as inspiration or sources of comfort when facing difficulties. Whereas in the examples were faith is seen not to help, the community is contemporary in nature, with recounting of lived experiences and encounters that have been the opposite of inspiration, instead leaving individuals discouraged and demotivated when looking inward for support.

The observation is an acutely important one and denotes the significance of mental health literacy in Muslim communities if young people are to find empathy, understanding and awareness amongst those with whom they live and breathe. Seeking solace in the stories of prophets of old is a familiar rejoinder in Islam but it cannot be a substitute for young people finding the support they need within their communities to talk about their difficulties and having at their disposal individuals possessing rudimentary knowledge of mental health so as not to shrug off their tribulations or put them down to "weak faith". As one participant noted, the refrain to "turn to faith" or "prayer heals all" can seem like an excuse to do nothing. Public health campaigns to tackle the stigma attached to mental health in wider society ought to be replicated in minority ethnic communities with a view to addressing problems besetting minority populations when it comes to helping young people talk about mental health and wellbeing. In the discussion groups, an oft cited lament was the absence of "inspirational role models". Individuals whom young people look up to could play a useful role when it comes to mental health awareness raising campaigns. Any public health campaign targeting minority populations should make use of role models to whom young Muslims can relate.

The effort at normalising mental health as a concern for Muslims rather than take the view that it "is not their struggle" was seen as resting on better training for families, communities and imams with better use of mosques as venues for disseminating key messages and providing young people with a place to turn should they seek out support. An interesting suggestion in a discussion group was the use of "clinicians to act as consultants for imams" thereby enabling the "education of educators" and thus a steady diffusion of mental health literacy into Muslim communities.[192] Another suggestion was for the use of better language and visuals when it comes to making mental health a subject of interest and concern in Muslim communities. As we saw in the section of mental wellbeing, young Muslims possess a competent vocabulary when it comes to articulating what good mental wellbeing means to them and what they understand to be mental health struggles. The absence of a faith-inflected vocabulary in their responses may allude to the inadequate ways in which the topic is currently talked about within Muslim communities and the need to inject an idiom that draws directly on the verses, prayers and stories of the prophets that young people rely on. Framing such verses, prayers and stories in the context of mental health and popularising their understanding in these terms is one way language and visuals can affect a demonstrable shift within Muslim communities.

192 The community mental health organisation, Sharing Voices, Bradford, has in the past offered a 'Listening Imam' service. See 'Three Keys to a Shared Approach in Mental Health'. Care Services Improvement Partnership / National Institute for Mental Health in England (NIMHE). 2008.

Suffice to say, without addressing the pejorative view young people have of "community" as ill-equipped, unwilling or unable to support them, attempts at using community assets, either imams or mosques, as a means to increase mental health awareness and referrals will likely fail. Messaging is not something to be limited to the communication of mental health messages, altering negative perceptions of communities must also be part of the campaign.

Another observation is the contrast between familiarity with ways in which faith is seen not to help, for example, guilt and cultural or religious norms that can seem oppressive or controlling, and ways in which faith is seen to help, such as forms of religious practice and spirituality. While the former is perhaps better studied in the literature, the latter is an area of growing interest and one that is particularly relevant to this survey. What we can see from the insights offered by survey participants is that faith is a multifaceted component shaping individual repertoires of tools and methods to deal with mental health struggles whilst also informing the wider cultural milieu in which faith is lived and learnt. This is not to say that the effects are universally benign, this section outlines areas where discordance both normative and practical, creates further challenges for those already dealing with mental health struggles. Nevertheless, the value premium placed by young Muslims on mental health services that are inclusive of faith and cultural sensitivity, as distinct factors not as a conflation, and which recognise the positive role faith can play when it comes to supporting mental wellbeing suggests inclusive services is not a request raised merely to conform to equality standards, though that in itself is vastly important in a diverse society. It is to improve the quality of care received and to increase the probability of successful interventions and treatment. That is something that is not just in the interests of young British Muslims, it is and ought rightly to be, in the interest of the mental health services sector too.

There is now widespread recognition of the effects the pandemic has had on the mental health of children and young people, with measures such as school closures, restrictions on social mixing and gatherings whether family or friends, curtailment of face-to-face teaching and the transition to remote learning for both school and university-level education, interruption to regular modes of assessment, particularly GCSE and A-level examinations, and the cost to child development of prolonged periods of interrupted schooling.

Young adults have also endured the high costs of lockdown and the ensuing economic uncertainty with job losses, redundancies and a negative economic outlook weighing heavily on the economic prospects and earning potential of young people. Fear and uncertainty about the future is a further factor that has contributed to the perceptible rise in low wellbeing and ill-mental health among young people.

For young British Muslims, there is yet an additional burden the pandemic has brought in its wake. The disproportionate number of people of ethnic minority background, Black, Asian, and other ethnic minority groups, who have been impacted by Covid-19 has contributed another layer to the existing educational, social and economic turmoil experienced over the past year. The high death toll among Muslims and other ethnic minority groups will inevitably lead to health concerns amid the feelings associated with bereavement, loss, grief and trauma that the pandemic has left in its trail.

Moreover, while national level lockdowns have affected the population at large, periods during which tiered restrictions were enforced in parts of the country have affected only certain sections of the population. The north west region and the Midlands, two areas that withstood prolonged periods under Tier 3 restrictions, and London, which latterly was placed under Tier 4 (along with the South East region) have experienced more serious bouts of restrictions than other areas of the country that have lived through lower-level tiers. The high ethnic population density in regions affected by Tier 3 and Tier 4 restrictions would suggest mental health issues arising from confinement, isolation and limited social interactions may be felt more acutely among these groups.

Mental health will be a subject of acute interest in the months ahead, as the vaccination programme makes rapid progress and we look forward to a future that is closer to our pre-pandemic existence. But as the Royal College of Psychiatrists warns, "when the virus is under control, the mental health effects are not over".[193] Ameliorating the effects of the pandemic on the mental health of young people will be high among future priorities to ensure those who have suffered one of the worst years in living memory are given the support they need to move forward with their lives and thrive well into the future. We hope young British Muslims will not be forgotten or overlooked in the drive to mitigate the huge costs of the pandemic on the lives of our young people, and we hope the analysis and recommendations we have set forth in this report can positively contribute to this vital work.

193 NHS mental health beds are full, Royal College of Psychiatrists warns, I*TV News*, 29 January 2021.

# Conclusion and recommendations

There are many insights into the mental health struggles experienced by young British Muslims that the survey has thrown up and many prospects to address what can only be deemed missed opportunities in the treatment and care of young people. The proportion of service users present in the survey emboldens the observations, analyses and findings presented here, and underpins the recommendations that are proposed as a way of communicating what young Muslims have revealed about their struggles to the sectors that have the capacity and responsibility to address their needs.

From the outset, it is worth noting the often-porous boundary between the three limbs of emotion, function and evaluation when it comes to how young Muslims understand mental wellbeing. There is not a tight boundary dividing these aspects, with frequent intermingling of concepts or values associated with one limb and another. It suggests a 'cluster concept' approach is more relevant than a tightly bound definition of what constitutes "good" mental wellbeing, incorporating aspects of states of feeling, states of acting or doing, and states of outlook, with a variable geometry of application in individual contexts based on the relevant weighting attached to each limb. Person-centric approaches that are championed in this report allow for these nuances and variations to be more accurately reflected in treatment methods and tailored interventions.

A second, significant observation on the findings is the centrality of faith to supporting young Muslims with their mental health struggles. Faith plays a positive role in supporting mental wellbeing among young Muslims, with the majority of participants (59%) agreeing that it does so. For young Muslims who have experienced counselling or therapy, the figures are marginally higher with 63% saying they would be likely to turn to faith when experiencing mental health struggles. Faith serves as a protective and supportive factor, acting simultaneously as a deterrent and a support when facing mental health struggles. The strong statistical correlations indicate the strength of association between experiencing counselling and preferring to see a Muslim counsellor or therapist, $r=0.997$; the importance attached by service users to mental health services being culturally/faith sensitive, $r=0.997$; and their believing faith has a positive role in supporting mental wellbeing, $r=0.997$. Turning to faith when experiencing mental health struggles and the belief that faith has a positive role in supporting mental wellbeing shows a further statistically significant correlation of $r=1.0$. This is applicable even among those who self-identify as being moderate or weak in their personal religious practice. Experiencing mental health struggles and a belief that faith has a positive role in supporting mental wellbeing bears out the strong tendency among young Muslims who view faith as a benevolent tool with, again, a statistically significant association of $r=0.91$. These correlations are major insights into what type of support and services young Muslims value and what they feel can make a difference to how they approach and access help.

But faith can also serve as a risk factor in some instances, acting as a channel to exacerbating struggles or presenting obstacles to resilience or recovery. Experiencing feelings of guilt, self-induced as well as being inflicted by others, and having other Muslims deride or dismiss mental health struggles as not something "good Muslims" struggle with can endanger those already dealing with fragile or weak emotional states. Moreover, glib prescriptions for Muslims to "pray more" as a means of overcoming mental health struggles can cause exceptional harm, both blocking young people from seeking help from those closest to them and underplaying what could later develop to become more serious mental health conditions. Suffice to say, for faith to play a positive role, its agents in society - imams, Muslim communities, Muslim families and Muslim networks, personal and professional - must be better equipped to recognise, refer and support those who seek help with mental health struggles.

Faith as a risk factor is not just present within internal contexts but also in external contexts, with overt displays of hostility and prejudice to Islam and Muslims and institutional racism also playing a part in aggravating the mental health challenges faced by young Muslims. While Islamophobia may be more readily recognised in the form of palpable bias, whether prejudicial social attitudes or acts of intimidation, discrimination or violence against people of Muslim background (or perceived Muslim background), there are also the insidious forms of unconscious bias and pejorative value judgements that prevail, which can leave young Muslims ridiculed for their belief in God or having faith and relying on it as a coping mechanism. Situating mental health services and practitioners within these wider contexts requires and should elicit forms of reflexivity to identify, address and challenge the ways in which Muslim identity is problematised in treatment rooms (and universities and workplaces), as much as it is in wider society, and the (un)intended consequences of this on young Muslims' mental health.

We set out below a series of recommendations based on the findings of our survey:

1. Diversity in the health workforce is an issue that has gained some prominence lately, due to the high proportion of medical professionals of minority background who have lost their lives on the frontline due to Covid-19. The pandemic has perhaps made us acutely aware of the status of diversity in the health sector and the challenges faced by those of minority background who work as healthcare professionals. There are now more strident calls for better workplace strategies to improve ethnic minority inclusion and promotion in the health sector, not least as a means of tackling the persistent health inequalities that beset the poorer outcomes experienced by those of ethnic minority background. These calls for better representation, inclusion and promotion extend to the realm of mental health services. Increasing the proportion of healthcare professionals in the mental health workforce who are of Muslim and ethnic minority background is a necessary step for improving quality of care and quality of outcomes for Muslim service users.

2. Strategies for the recruitment and retention of the mental health workforce, as outlined in 'Stepping Forward to 2020/21: The mental health workforce plan for England', should contain specific plans and targets for the recruitment and retention of staff of Muslim and ethnic minority background.

3. Plans for increasing the proportion of Muslim and ethnic minority healthcare professionals working in mental health should have board-level accountability to ensure targets are met and workforce indicators are regularly monitored for progress.

4. Periodic assessment or audits of equality on the basis of religion or belief must also be part and parcel of strategies to improve diversity in the workforce and outcomes for Muslim service users. Better data collection on religion or belief is an important mechanism for audit transparency, and healthcare institutions must improve the quality of data recorded on religion to enable full and proper scrutiny of their progress on diversity and service delivery.

5. Training, professional development and religious literacy programmes run by specialist providers, such as that offered by the Department of Psychology at University of East London, are fundamental to robustly and holistically examining why, how and when faith can support young people in their mental wellbeing and mental health. Person-centric approaches that work with the repertoire of resilience tools valued by service users, not discard them as outmoded or irrelevant, engender a degree of faith and cultural competency that should be sought from accredited sources and integrated into continuing professional development of the mental health workforce.

6. Mental health charities, voluntary sector organisations and independent providers are components of the wider mental health workforce and recommendations outlined here on recruitment, retention, representation and diversity monitoring should apply equally across these partner organisations. Given the level of public funding provided to mental health charities and voluntary sector organisations, it is vital their services reflect the diversity of service users who access help and support. Mental health charity organisations must take urgent steps to address the level of diversity across their workforce.

7. Increasing numbers of young Muslims enter British higher education each year and it is vital that universities implement their duty of care in a manner commensurate with the religiously diverse nature of the student population. Students comprise a third of our survey sample and the insights shared here are relevant to higher education institutions and the kind of support they make available to students on campuses across the country. Mental health support services provided by university institutions must have due regard for faith and cultural sensitivity to ensure Muslim students have access to services that are suitable and appropriate to their needs.

8. Both universities and the Office for Students (OfS) must recognise the impact Islamophobia, discrimination and structural racism can have on the mental wellbeing and mental health of Muslim undergraduate and postgraduate students, and should actively ensure they are provided with adequate access to mental health support during their time at university. Additionally, universities and the OfS should use University Mental Health Day, on 5 March each year, as an opportunity to raise awareness among students of mental health support services available on campus, and publish annual data recording year-on-year progress on mental health support access, take up and outcomes.

9. Workplaces are an incredibly important arena when it comes to matters relating to diversity. Studies show that workplaces can often be the most important place individuals encounter those of different ethnic and religious background. Full and part-time employees comprised over half of our survey sample. Making workplaces inclusive environments that robustly tackle racism and support the mental health needs of their workforce is essential for businesses and employees alike. Toolkits, such as the Mental Health and Race Toolkit developed by the City Mental Health Alliance, can help businesses support their ethnic minority employees to thrive in the workplace both individually and as a group. Adopting practical measures, such as the four key targets highlighted in the toolkit (namely: Challenge all forms of racism in the workplace; Build inclusive and representative mental health and wellbeing support; Allocate Board level responsibility;and Measure progress) can help ensure an employer is recognised as championing a mentally healthy workplace by existing and prospective employees.

10. Universities and workplaces should be encouraged to sign up to the Prevention Concordat for Better Mental Health in order to take measurable steps toward building the capacity and capability within institutions to prevent mental health problems and promote good mental health. The Concordat has thus far been signed by national statutory organisations and professional bodies, local authority and local health partnerships and national voluntary, community and social enterprise organisations. Universities and workplaces should also join to become part of the cross-sector approach endorsed by the Concordat.

11. New government plans to introduce a Patient and Carers Race Equality Framework and “culturally appropriate advocates”, as part of reforms to the Mental Health Act in the new Mental Health Bill expected in 2022, and the development of a Patient and Carers Race Equality Standard should take due consideration of religion as well as race when it comes to reforming mental health services to ensure they are better designed to deliver an outstanding quality of care Britain’s diverse population. Faith as a protective factor when it comes to mental health should receive better attention and the use of “culturally appropriate advocates” should include “faith advocates” too, as separate and distinct from culture. This is consistent with the government’s manifesto pledge to ensure services are “person-centred” and should be given due consideration in the future planned reforms.

12. Faith is also a tiered factor when it comes to protective, supportive and risk assessments. At a personal level, faith is a powerful force for resilience and a valued tool for guarding against, coping with and managing mental health struggles. But at a communal or social level, that is within communal and societal contexts, faith, or rather preconceived notions and attitudes towards faith among Muslims as well as others, can incite aversion to its recourse. Individual experiences of interacting in communities and social attitudes towards Islam and Muslims in the UK can and do play a role in how effective faith can be to individual strategies on coping and resilience. A more sophisticated discourse on faith and mental health is a necessity not just in the mental health sector but also, crucially, within Muslim communities. Such a discourse should clearly delineate religion from 'culture'. It should also seek to understand culture within British Muslim contexts as a plural phenomenon encapsulating a wide range of ethnicities and nationalities not simply (or lazily) constructing it through a (south) Asian lens.

13. Critical views of the 'professionalism' of Muslims working in mental health sector is an issue of concern and one that should be explored more deeply. A critical, reflective discourse among Muslim mental health professionals and a clearer delineation between Muslim professionals working in mental health as part of a wider strategy to mainstream culture and sensitivity in service provision and 'Islamic counselling' could help with this. Organisations like the Muslim Counsellors' and Psychotherapists' Network (MCAPN) can play an important role in facilitating dialogical encounters and exchanges between Muslims working in mental health services and Islamic counselling practices as a means to improve religious literacy in mental health services, and to break down negative perceptions regarding Muslims' professionalism in the sector. Collaborations and partnerships between mental health services and Muslims' professional networks in the mental health sector are key to bridging the gaps.

14. Platforms such as MCAPN can also play a hugely relevant role in raising levels of mental health literacy within Muslim communities. The importance of mental health literacy within Muslim communities cannot be understated particularly in relation to peer and family support when it comes to signposting and referring for help. More than half of young people who have experienced mental health struggles say they have turned to friends, 52%, or to family, 30%, when undergoing difficulties, with one in five seeking help through therapy, 20%. Young peoples' reliance on peers and family networks makes mental health literacy as a community-wide initiative of vital importance.

15. Mental health literacy in Muslim communities should get creative and be more expansive, drawing on the wealth of information and references in Islamic sources to build a reliable and formidable discourse on human flourishing in Islam. We can clearly see how religious practice and spirituality are used by young Muslims to support them in their mental health struggles. Their reliance on their faith ought not to proceed from a self-taught basis but should be supported with language, vocabulary and a discourse that explores religious narratives and texts such as Prophet Muhammad's 'Year of Sorrow', Surah ad-Duha (Chapter 93), Surah Ash-Sharh (Chapter 94) and stories of the prophets and their tribulations as related in the Qur'an. Normalising young Muslims' repertoire of resilience tools should be as applicable to Muslim educators (imams and parents) as it is in mainstream service provision. This forms part of the dialogic between religious literacy in the mainstream and mental health literacy within Muslim communities, with both enriched and expanded by the respective insights offered. As Professor Jim McManus put it in his conference presentation, Muslims need to "get their theology talking to science" when it comes to mental health.

16. Muslim communities also have a role to play when it comes to utilising "place-based" assets such as access to community resources like mosques. Challenging the cultural and social stigma attached to mental health in Muslim communities requires the use of those spaces and places where religious nurture takes place. Mosques as community resources for the promulgation of learning are instrumental to the raising of mental health awareness and mental health literacy in Muslim communities. They must rise to this challenge and meet it head on.

17. Lastly, on the role of Muslim charities and philanthropic foundations. As ever, when it comes to positioning a series of asks the question that inevitably follows is “who will pay for it?”. In devising the survey, hosting the conference and initiating work with The Children’s Society on mental health and children, BCBN has taken tentative steps towards prioritising young Muslims’ mental health in its future work strategy. But it should not be a lone voice or actor in recognising how important it is to understand the mental health struggles of young Muslims and identifying ways in which they can be better supported in access to services, in communities, and in society more generally. We hope this report and its uncovering of hidden survivors will provide the prompt needed so that more Muslim charities and philanthropic foundations will consider how to embed improving young Muslims’ mental health in their future work programmes.

# Social prescribing and mental health

Professor Rachel Tribe, Professor of Applied Psychology at the School of Psychology, University of East London, and Professor Aneta Tunariu, Professor of Applied Psychology and the Dean of the School Psychology at the University of East London

### What is social prescribing?

Social prescribing is intended to support people to "..improve their health, wellbeing and social welfare by connecting them to community services which might be run by councils or local charities" NHS England (2019). Each GP practice will have a social prescription link worker by 2023/4 who will develop local working groups and support services. Social prescribing has the potential to be paradigm-changing for mental health provision. "It forms part of a wider health strategy to provide 'person-centred' interventions within a preventative model of healthcare. It is hoped that social prescribing will reduce health inequalities, deliver community-based care and increase local accessibility " (NHS England Long Term Plan, 2019). Social prescribing focuses on activities which are non-medication based including the arts, physical activity/sport, health education and community involvement. NHS England recognises that all of these can positively contribute to mental health and wellbeing.

### Can social prescribing embed diversity and inclusion and play a role in tackling health inequalities among BAME groups?

Social prescribing provides an opportunity for third sector organisations which have been run on a voluntary or small budget to obtain recognition and funding for the important services they offer and seek funding for new services. It can ensure that services offered are more accessible, appropriate, are local and are tailored to the needs of diverse user groups, with relevant cultural and faith-based issues prioritised in this service provision. This has the potential to play a role in tackling health inequalities for BAME groups. Also, issues of stigma may be minimised by people attending culturally and faith-based projects funded through social prescription. Although a systematic review queried the current evidence base for social prescribing (Bickerdike et al, 2017). It is important to realise that social prescribing is in its infancy. Rigorous in-depth research is currently being undertaken.

### Possible unintended consequences of social prescribing

These include inadequate or tokenistic funding or the available funding being viewed as sufficient to address issues of inclusion in health care and provide diverse services, while current issues of service access and health inequalities are merely continued in other services. Thus, it has the potential to lead to marginalisation or lack of integration of services for certain groups. Medical hierarchies and traditions may position social prescription link workers with limited status and pathways to this service. Commitment and leadership from the top of the NHS to work with and learn from BAME communities is essential to developing strategic and real partnerships to openly consider power dynamics and issues of racism and inclusion. The services offered will need to be varied and linked to the cultural and faith of the communities that they serve. In addition, some service users may view social prescription as an inappropriate intervention/ treatment for their requirements. They may wish to keep their mental health issues private and might view referral to a community or other project as insensitive. Social prescribing may not fit with the health model commonly held by some people. Any projects applying to become part of social prescribing need to be clear about these issues and consider how they might consider these issues. Previous strategies to meet the needs of members of BAME communities have not met with universal success, and this could happen again if social prescribing is not adequately funded and the views of different communities foregrounded. Although social prescribing has the potential to make a significant and important contribution to mental health provision.

Bickerdike L, Booth A, Wilson PM, et al (2017) Social prescribing: less rhetoric and more reality. A systematic review of the evidence. BMJ Open 2017;7:e013384.

**NHS England (2019) www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/**

# A Public Health perspective

Nuzhat Ali,
Chair of Public Health England Muslim Network

Public mental health is a global and national public health priority. The World Health Organisation's Mental Health Action Plan and a recent Lancet commission on global mental health prioritises population approaches to mental health promotion and prevention. Nationally, the UK Government calls for parity of esteem, recognising that prevention activity is mainly focussed on physical health and that more attention is needed on improving everyone's mental health, with a wider consideration of mental wellbeing.

Good mental health and wellbeing for all our population will not be achieved through the actions of a few National Health organisations, nor through single interventions addressing single factors alone. A 'whole system approach' to public mental health is needed, acknowledging the inter-relationship of different factors influencing mental health and the range of interventions and sectors working across the life-course with all communities and at different levels of influence. What does a 'whole system approach' to tackling mental health and wellbeing for our Muslim youth look like? Whole system thinking is achieved when a wide range of stakeholders, organisations and communities work more effectively together as part of a whole system approach (WSA). Such as parents, schools, education providers, mosques and Muslim community centres, the NHS and other health providers, third sector mental health organisations, Police, and criminal justice system. The role of Muslim health professionals, who work in and with Muslim communities, is important in facilitating and supporting a greater understanding of the cultural issues and the intersectionality of faith, ethnicity, and gender on service provision and to achieving better health outcomes for Muslim populations in England.

Muslim community-based organisations, such as mosques, schools and charities, need to engage and partner with statutory service commissioners, providers and third sector organisations such as MIND, Young Minds, Inspirited Minds and others, in order to collaborate and form an understanding of the local issues, context and wider systems; create a collaborative prioritised plan for action; and ensure there is monitoring and evaluation in place to ensure progress is being made in the right direction.

A public health approach to mental wellbeing includes:

1. Tackling the risk factors: Adverse Childhood Events (ACEs), violence, poverty, problem debt, housing insecurity, social isolation, bullying and discrimination, Islamophobia.
2. Investing in the protective factors: strong attachments in childhood, living in safe and secure homes, access to good quality green space, security of income, strong set of social connections
3. Mental health literacy: people's knowledge, skills and confidence in looking after their own mental health

The Muslim Health Collaboration each year identifies one corporate health objective that adversely affects the Muslim community in England from the statutory health bodies plans. In 2019 we focussed on mental health and wellbeing to raise awareness of the inequalities, stigma and lack of focus on BAME and Muslim communities. Our focus on this helped Muslim organisations to sign up to Public Health England's Mental Health Prevention Concordat, and raised awareness of what Muslim professionals and organisations could do, in addition to opening the conversation with statutory organisations.

# How universities can help promote good mental health for Muslim students

Simon Blake OBE*
Chief Executive of Mental Health First Aid England

According to the National Union of Students (NUS) there are approximately 330,000 Muslim students in UK Universities and Further Education Colleges.

As well as having a clear academic purpose, Universities are important places for students to develop and grow in personal understanding, to meet people with varied life experiences, different backgrounds and a range of different faiths and beliefs.

Whilst Higher Education institutions around the world are often at the forefront of challenging racism and promoting greater understanding of faith and diversity – whether in the curriculum or on campus – research carried out by NUS (2018) showed many Muslim students continue to experience Islamophobia. This is clearly unacceptable.

Universities and students' unions have an important role to play in ensuring that the student experience is a good one for all students. It cannot be the responsibility of any one person to ensure campus is safe and welcoming for Muslim students. Everybody must have an awareness and understanding of the particular issues that Muslim students face on campus.

The vast majority of Muslims in the UK come from South Asian and Middle Eastern backgrounds. Generally, discussions about mental health are not as open as they would be here in the UK. Universities that understand this cultural context for young Muslims regarding discussions about mental health are better placed to ensure support on campus is culturally appropriate, sensitive and relevant.

A key principle is to connect and engage with young Muslims in the environments they feel safest in, which will often be their student societies. This is why Universities must reach out to Student Islamic Societies and cultural societies to support them in the work they do creating positive environments for Muslim students. In 2017 the Federation of Student Islamic Societies (FOSIS) ran a campaign *Mind Over Chatter* (https://www.fosis.org.uk/mind-over-chatter/mental-wellbeing/) about young Muslims and mental health. As a trusted agency FOSIS was able to generate positive conversations about mental health.

Many Muslim students will be International Students who often face many of the cultural barriers and are without support structures in the country. Universities can helpfully employ engagement strategies, and ensure students are aware of the support structures available. Like with home students, Societies are a core point of contact to reach these students.

Islamophobia from other students, lecturers and tutors is a day-to-day challenge for many Muslims. The existence of safe, confidential reporting lines that Muslim students have confidence in is critical for wellbeing. Prayer rooms are an important space for Muslim students facing emotional distress to seek support.

The social element of University can have a serious impact on the wellbeing of young Muslims. Whilst there have been some improvements in diversifying social activities in recent years, it can still feel like alcohol-based activities and bar culture are key to integrating with classmates. If you feel obligated not to participate for religious reasons, this can cause distress. Many Universities appear to underestimate just how much of a challenge this is.

Universities UK Step Change Framework provides a tool for Universities to understand the needs of all staff and students (https://www.universitiesuk.ac.uk/stepchange). In thinking about the needs of young Muslims, Universities can helpfully:

1. Recognise that Islamophobia is part of all institutions and take action to tackle it however it manifests itself
2. Make it clear in their prospectus' and other material that hate is unacceptable. Be clear that it will be taken seriously
3. Have anonymous reporting structures for hate crimes including Islamophobic incidents
4. Ensuring course curricula are diverse and reflective
5. Ensuring campus spaces are genuinely accessible for all. It is probably helpful to start with the assumption they are probably not open and safe to all. Make sure you know who is using them and who isn't and why.

Most important of all, Universities must find ways to listen to and engage with Muslim students about their University experience and what they can do to support positive experiences, inclusion and wellbeing. Muslim students will have lots of ideas. If you ask for them, it is important to act on them.

Mental Health First Aid England (www.mhfaengland.org). MHFA England is a social enterprise with a vision to improve the mental health of the nation.

*Thanks Ali Milani - a past president of Brunel University Students' Union, past Vice President of the National Union of Students (2017 - 2019) and member of Labour Muslims Executive - for input.

# Young people give me hope

Poppy Jaman OBE

Chief Executive, City Mental Health Alliance. Formerly, founding Chief Executive of Mental Health First Aid England.

At the City Mental Health Alliance, our vision is to create a mentally healthy workplace. Our vision is to be a global organisation, where businesses can come together to collaborate to address this very challenging issue of the workplace and how to move from raising awareness of mental health to creating health at work. Raising awareness is about questioning what is mental health, how does it lend itself to our lives, and where are the pinch points in our lives where work can be supportive. For example, when young people are transitioning from higher education into workplaces, that can be a really challenging time with increased stress levels, so workplaces can go a long way to ensure that they are promoting their mental health services, designing their graduate work schemes, programmes and internships to be inclusive and supportive so that people can bring their whole self to work. Another pinch point would be parenting –when young people are starting families, particularly women for whom this can have a disproportionate impact on career progress and opportunities.

We are trying to create a very strong sense of belonging in the workplace for everyone where you can feel that work is part of your mental health and wellbeing toolkit. Flourishing is the term that I use to describe what it is we're trying to achieve - creating working conditions and a workplace culture where people can flourish.

In order to create health equality, we need to address the social determinants of health and specifically, the social determinants that are economic, such as being able to get a job, having access to a healthy home environment, surroundings, networks, family, skills, education, food and transport. We know that people of Black and Asian backgrounds have less access to good work and tend to live in overcrowded households. We know for young people, they don't have access to networks that could provide opportunities, mentors, coaches, the kind of support structure that can enable them to thrive and achieve their full potential. I feel very lucky that I came across people in my life who opened doors for me to go on leadership programmes but most young people don't have those network and I think that's really a key factor in helping our young people.

Organisations I have worked with have been using mental health skills development strategies which have been developed over a decade. It advances multiple ways to promote wellbeing in the workplace which organisations have adopted:

1. Educating line managers - anyone who has management responsibility must undertake some form of education in mental health
2. Strong employee assistance programmes (EAPs) - including six to eight sessions of talking therapies appropriate for people of ethnic minority background
3. Digital applications for everything from suicide prevention to common mental health issues such as anxiety and depression.
4. Access to physical health and wellbeing interventions - via promotion of relevant applications
5. Availability of high-quality information on mental illness and mental wellbeing, especially where someone can get help and support

Actions some organisations have practiced during the pandemic include line managers doing check-ins, reverse mentoring and mutual mentoring. Essentially, this is about socialising the mental health agenda within a workplace - talking about mental health in everything we do in the workplace. So, thinking about the impact of working from home on people and knowing that means you can design new patterns of working.

It's about skilling-up the organisation, having managers or colleagues who are comfortable with asking 'how are you?' and there being support available for those who need it. This skilling-up in the organisation is really crucial, as is saving the change.

One of the things we are doing is aligning how we make mental health and wellbeing a boardroom agenda. For all the organisations we work with, it is a boardroom agenda. There's a report that goes to the board at different points of the business cycle that is about staff wellbeing. Normalising the conversation around mental health diversity sits within that and then skilling-up the organisation at every level and creating accountability at senior levels to make change happen and to see these changes reflected in the workforce. It has been very refreshing for me to see city corporates drive this change by talking about health inequalities and how to plan for the new patterns of working around mental health and wellbeing.

Young people give me hope – they really do. They are creating change. I hope that with their energy, the younger generation can continue to be a strong voice because it's their future. We are slowly creating diversity at board level and making sure we're inclusive and attracting the right level of talent, and business leaders are becoming very serious about this. Activism on the race agenda, global connectedness and solidarity, and action plans with data and transparency, make me hopeful that the next generation won't put up with inequalities and they will be holding up a mirror to our generation.

# Securitising mental health, racialising Muslim bodies

Dr Tarek Younis,
Lecturer in Psychology, Middlesex University

It is very important to note that there is no actual profile of vulnerability or mental health which is associated with radicalisation. And yet, over the years, the Government's Counter-terrorism strategy, Prevent, has positioned itself as a strategy for the "vulnerable"—and mental health is key in this regard. In other words, Prevent has essentially rendered all vulnerability suspect and this has particular consequences for those accessing mental health services. This is exactly what is meant when it is said that Prevent is "policy-based evidence" not "evidence-based policy." It's a policy driven by moral panic and the 'common sense of the public' which, again, tends to psychologise behaviours we don't fully understand. As Medact, and myself, have documented, the result of such a policy is quite simple: by securitising mental health, Muslims, especially those aware just how much Prevent is psychologised, are left fearful of sharing their vulnerability and their politics. Through the logic of racist policies—very much like others such as Stop and Search, Hostile Environment, etc—the average person is much more likely to associate Muslim vulnerability with radicalisation than they would a white person. This is what is deemed the privilege of 'white innocence'.

Institutional racism is often erroneously reduced to questions of individual prejudice. Institutional racism rather has to do with the policies and structures which are themselves racialised and which make particular bodies and behaviours more apparent. For example, as we know with the police, a mandatory stop and search policy is going to discriminate against black youth simply because black bodies are more readily associated with crime and criminality in the public's imagination. The same can be said about Muslims and those racialised as Muslims, though the racialisation of Muslims is more complicated as it involves not just their bodies but also their religious practices more generally.

We already know that Muslims experience discrimination in healthcare settings due to the association of Muslims or Islam with a threat, backwardness and foreignness etc. Now imagine the impact when this 'common sense intuition' becomes institutionalised. For example, in my research, a Muslim woman wearing niqab told me she went to see a therapist and he said one of the "signs of successful treatment" would be her ability to remove the niqab. While this is itself egregious, it gets worse: this Muslim woman immediately feared a Prevent referral. Is she going to be referred to Prevent? She'll never know and it's impossible to tell—she just knows she can never go back to an NHS mental health professional without facing that risk. This is very important when we think about institutional racism. We need to think about the policies and structures which provide the institutional incentives and burdens which allow others to act upon their racist prejudices, not "train them away."

In my view, "culturally-sensitive mental health" cannot only be sought through better training or diversity. This is well recognised in antiracist scholarship. There are two answers to this dilemma for Muslims moving forward. First, to challenge policies which perpetuate and institutionalise 'commonsensical' racist logics and inevitably result in racist consequences. Second, and perhaps the more immediate, need that we have is that there are Muslims right now who come to me almost on a daily basis requesting mental health services which are not securitised. This now begs the question what we do with these individuals, given that we can no longer just recommend they go to the NHS and hope for the best. There is a collective responsibility on the Muslim community to provide a safe space for those vulnerable in our community that are deserving of safe spaces to share their vulnerabilities, free from fear of securitisation.

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