

# **Spirituality and Mental Health: Focus Groups with Faith leaders in a Religiously Diverse London Borough**



**Roxanne Keynejad**

Redbridge is an ethnically and religiously diverse borough affected by psychiatric inequalities. It has long been known that spirituality plays a pivotal role in mental health and access to treatment but this has not been explicitly explored in this region. This essay describes the rationale, design and outcomes of a pilot project exploring the mental health needs and roles of community faith leaders in a borough whose population is analogous to many communities in an increasingly cosmopolitan British society. It discusses the policy and research background to the focus on spirituality in psychiatry and presents the findings of qualitative focus groups with faith leaders. It ends with recommendations for partnership between statutory services and community workers, to ensure that patients' cultural, spiritual and religious needs are integrated into psychiatric service provision at every level.

## **Introduction**

### **The Local Context**

Redbridge is the ninth most ethnically diverse local authority in England and Wales (51.9% White, 16.9% Indian, 17.2% Other Asian, 11.3% Black<sup>1</sup>), with a correspondingly varied religious and spiritual population. Population projections reveal growing percentages of ethnic minority groups, with corresponding growth in the borough's religious and cultural diversity. Redbridge has the fourth highest Hindu (7.8%), Jewish (6.2%) and Sikh (5.5%) residents in England and Wales, the twelfth highest Muslim (11.9%) and the tenth lowest Christian (50.7%) residents in England.

Religious communities may interpret mental illnesses differently and have preferred modes of help seeking. In order to engage these communities with psychiatric services, spirituality cannot be ignored. A North East London NHS Foundation Trust (NELFT) audit<sup>2</sup> found that low numbers of inpatients were asked about their spiritual needs, despite high percentages wanting to be asked. The majority found nothing in the environment to help them to explore their spirituality but felt this would have been helpful for recovery:

*If you talk about spirituality and spiritualism they think you're mad... so my friends, we say 'Don't let on too much'... it creates a barrier between the staff and patients.*

The necessity of meeting spiritual needs in the clinical setting is clear, but has resource implications for ward staffing and risk assessment. Whilst community and faith sector volunteers can be valuable, the importance of appropriate training should not be under-stated.

## Psychiatric Inequality and Spirituality

Redbridge's psychiatric services, like most in the UK, experience over-representation of Black patients and under-representation of Asian groups<sup>3</sup>. Both statistics indicate disparities in understanding of mental illness and knowledge of available services in these ethnic minorities. A recent report<sup>4</sup> found that spirituality is integral to the mental health of Redbridge communities, including White British groups. For example, young African men interpreted psychotic symptoms within a spiritual framework and advocated help seeking from religious leaders whilst South Asian patients highlighted faith as critical to recovery. This was not a new observation. The National Institute for Mental Health in England, Mental Health Foundation and Royal College of Psychiatrists all have subgroups focusing on spirituality. Despite high profile discussions of this issue<sup>5</sup>, however, it remains neglected. *Keeping Faith* investigated spiritual needs in the neighbouring borough of Newham:

There was a fear [among patients] regarding talking about those [spiritual] beliefs because it was thought that if they did so, they would either be sectioned, placed on medication, or seen as exhibiting psychotic symptoms.

Many mental health workers with whom I spoke saw the whole complexity of religious beliefs as far too complicated to engage with, and many saw religious belief as contributing to mental health problems... those who sought help went first to their Faith Community.

This commonly reported view, that faith may exacerbate mental illness, contradicts a growing body of evidence that spirituality is beneficial to mental health and recovery<sup>6</sup>. Copsey continues:

Many people with whom I spoke, drawn from all religions, said they dreaded going into a hospital or day centre because there was nothing in those buildings which enabled them to express their faith. When I asked what they wanted, many said they wanted a place for prayer, contact with their religious community, and staff who wanted to talk to them about their faith.

The belief system underpinning nearly half the population of Newham is grounded in non-western culture. This culture has a long history of integration between the body, mind and spirit. Spiritual values are an essential part of life. There is no dichotomy between the secular and the spiritual. Life is sacred. The transcendent is part of life. Such a belief system permeates the whole of life. This is very hard for those with a western world view to understand.

Mental health services in increasingly diverse boroughs must address spirituality in recovery if they are to engage with local communities and deliver truly patient-centred care.

## The National Context

A wealth of national policy supports the integral role of spirituality in mental health and the importance of supporting the religious needs of patients suffering from psychiatric illness. From the Department of Health to the United Nations<sup>7</sup>, its role in health and wellbeing is undisputed. Indeed, the coalition government strategy, *No Health without Mental Health*<sup>8</sup> states:

If positive outcomes are to be achieved, services will need to incorporate religion and belief into the assessment of individuals. Local services will achieve better outcomes if they make resources and facilities available for people to express their religion or belief.

The strategy acknowledges “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” and makes the key link between spirituality and:

...Other aspects of identity (for some cultures ethnicity and religion are virtually inseparable). Service data show that more people from BME [Black and Minority Ethnic] backgrounds identify themselves as religious. By failing to address religion, services disproportionately affect people from BME backgrounds.

Importantly, the same emphasis is found in patient-led research. For example, over 50% of service users<sup>9</sup> had a spiritual belief considered important to their recovery. A more holistic understanding of mental health is supported by the World Health Organisation’s constitution, with health “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity”<sup>10</sup>.

Including faith workers in mental health promotion supports key national policy. The *National Service Framework for Mental Health*<sup>11</sup> highlights the importance of the “spiritual facets of mental health and mental health problems” and “recognition of spiritual needs and beliefs in assessment and care planning”. *Delivering Race Equality*<sup>12</sup> highlighted inequalities in mental health among ethnic minorities in Britain. Its three priorities: more appropriate and responsive services, better information and community engagement are all addressed by research with faith communities.

Moreover, the Department of Health<sup>13</sup> supports the role of faith:

A holistic approach to the patient, which takes account of their physical, cultural, social, mental and spiritual needs... Attention to the religious and cultural needs of patients can contribute to their wellbeing and, for instance, reduce their length of stay in hospital.

The Mental Health Foundation<sup>14</sup> highlights positive practice in delivering spiritual care within psychiatric services. Many of these activities are delivered by local voluntary and faith sectors in the community. The policy acceptance of spirituality’s benefits to mental health largely contrasts with clinical delivery of psychiatric treatment. One reason may be the view that within a rigorous scientific tradition, there is no place or value for engaging with something ephemeral. Spirituality may

be viewed as “irrational, outdated and dependency-forming” by healthcare professionals<sup>15</sup>. Clinicians may be afraid of “overstepping professional boundaries”, encouraging delusions<sup>16</sup> or may not relate to their patients’ experiences. Furthermore, there is a ‘religiosity gap’: psychiatrists and psychologists are significantly less religious than their patients<sup>17</sup>.

## The Research Base

Academic research in the growing field of psychiatry and spirituality suggests a positive relationship between religion and mental and physical health:

One of the best-kept secrets of modern epidemiological medicine is the effect that religious belief and practice have upon outcome from both physical and mental disorders. Twelve hundred outcome studies and 400 critical reviews have formed the subject matter of the *Handbook of Religion and Health* by Koenig *et al* (2001)<sup>18</sup>. On all of the 13 factors for improved mental health, religious belief proved beneficial in more than 80% of studies, despite very few of these studies having been initially designed to examine the effect of religious involvement on health<sup>19</sup>.

Whilst isolating the benefits of spirituality in mental illness is difficult, compelling evidence supports the positive views of service users and policy makers. Religious coping is common in psychiatric and physical illness<sup>20</sup>. Positive religious coping, such as faith in a supportive God, correlates with reduced psychiatric symptoms after life events compared to non-religious coping, although these findings are cross-sectional<sup>21</sup>. Religion provides comfort and hope in psychiatric illnesses including schizophrenia and regular prayer is associated with reduced readmissions. Spirituality<sup>22</sup> furthermore affects physical health determinants, associated with reduced smoking, alcohol abuse, stroke and heart disease.

Spiritually-guided psycho-education groups may enhance insight into mental illness and life’s spiritual dimensions<sup>23</sup>. The therapeutic effect of religious architecture, art and music is also supported<sup>24</sup>. Religious attendance correlates with fewer suicide attempts, independent of the effects of increased social support<sup>25</sup>. Faith may be central to recovery and ‘reconstruction of a functional sense of self’ in psychosis<sup>26</sup>, although ‘spiritual despair’ is also documented<sup>27</sup>. Religious involvement is associated with reduced substance misuse<sup>28</sup>. The loss of purpose in life which comes with ill-health may be regained through spiritual activities<sup>29</sup>. Faith may enable reinterpretation of difficult circumstances, provide hope and communion with God in suffering. The religious community’s encouragement to reach out to others may be one mechanism<sup>30</sup>. There is, however, potential for negative effects. Guilt, ritualised behaviour, suicidal ideation, familial strife and dependency on religious leaders are also described.

While spirituality may be therapeutic, evidence suggests that faith communities may be less likely to seek help. Qualitative interviews show orthodox theists are reluctant to use mainstream psychiatric services<sup>31</sup>. Barriers to help-seeking include stigma and fear of violating religious law. Psychiatry may be met with concerns about how ‘kosher’ (religiously acceptable) it is in Jewish and other faith communities. A

psychiatric history can impact negatively on marriage prospects and be stigmatising, while treatment can be viewed as godless and to be avoided. Patients may favour culturally sensitive services delivered by their own community<sup>32</sup>.

A study of East London Muslims<sup>33</sup> found distrust of mainstream psychiatry. Participants saw services as custodial and felt psychiatrists did not understand their culture, with mental illness ascribed to Jinn spirit possession. Rather than seeking help, participants attended Imams and healers, often at great expense. 'Islamophobia' may have significant negative effects upon the mental health and treatment of Muslim families and children, with the literature suggesting that services fail to meet the needs of Muslim patients<sup>34</sup>. This is unsurprising, given the minimal training in spiritual assessment received by clinicians. Some patients have highly negative experiences of religion, their illness ascribed to Satan or possession<sup>35</sup>, some even enduring ceremonies to vanquish the 'spirit'. Such 'cures' may exacerbate isolation and reduce help seeking<sup>36</sup>, which could be remedied by better education about mental illness and services for faith communities. While faith leaders could form a major bridge between their communities and statutory services, they remain under-utilised. Spiritual leaders are often overwhelmed with pastoral and counselling work and welcome professional support<sup>37</sup>. Rabbis and Imams acknowledge their lack of knowledge of mental illness and desire to learn more<sup>38</sup>.

The importance of spirituality in mental health is demonstrated by policy and academic research. In an ethnically and spiritually diverse nation, the opportunity to engage faith leaders with psychiatric care pathways remains neglected. Two voluntary sector organisations, Redbridge Concern for Mental Health and the Redbridge Faith Forum therefore resolved to work with faith leaders to capture their concerns and experiences regarding mental health and illness.

## **Method**

### **Focus Groups**

Six evening focus groups were held for two hours at places of worship with Buddhist and Zoroastrian, Christian, Hindu, Jewish, Muslim and Sikh faiths. Focus groups were selected to yield as rich a narrative as possible and encourage participants to discuss mental illness. Detailed notes were typed on a laptop and made fully anonymous.

Each participant read an information sheet (Appendix 1) and signed their consent to participate. Later, a draft report was emailed to them and corrections requested, to ensure views were accurately recorded. Ethical approval was not sought as this project was a community audit and participation was voluntary.

Groups began with a PowerPoint presentation about mental health in Redbridge, using statistics about prevalence, employment and the role of stigma (Appendix 2). Two facilitators posed questions about mental health in their faith community, how people seek help and the role of faith in recovery, seeking clarification when needed.

Hindu, Muslim and Sikh discussions were facilitated by Punjabi and Urdu/Hindi speakers who translated comments for the group and typist.

## **Participants**

62 faith community participants attended focus groups: 51 male and 11 female. Ages were not documented but most attendants were in their forties and fifties. Numbers per group ranged from 4 (Jewish group) to 23 (Muslim group). Participants included Redbridge Faith Forum trustees, clergy (rabbis, ministers, Buddhist monks and Imams), faith counsellors and lay people. Participants were invited to attend by faith workers at each venue.

## **Limitations**

Unfortunately, male and female participants were unequal. This may have been due to timing or sex imbalance among faith leaders. This means bias is likely in the problems identified. For example, women expressed concern about forced marriage and women's depression. With more time and resources, a separate group would be held in working hours, for women. This must be considered when organising training.

The public focus group approach may have stopped participants from expressing embarrassing or controversial views. Since participants were self-selecting, those who attended may have differed from the population. The sample was not wholly representative of the Redbridge faith community, so findings may not express all views. However, this is a valuable start in engaging faith communities.

## **Strengths**

The focus group method enabled faith workers to candidly express their views on mental illness in their community. Despite high levels of fear and stigma, participants were open about their thoughts and experiences. They showed enthusiasm for mental health training and commitment to supporting vulnerable community members. The method enabled a relatively large number of views to be sampled, with a modest budget in a short time.

## **Results**

Common themes emerged between focus groups of different faiths. These were grouped to yield a set of conclusions about mental illness in Redbridge faith communities, illustrated by quotations.



## 1) Faith groups: Front line services

Faith communities provide significant social support to people with psychiatric illnesses. Spirituality plays a crucial role for many individuals and families experiencing distress. Furthermore, spiritual practices, from prayer to meditation, provide comfort and a focus for recovery. Faith workers act in emergencies to care for people in crisis and often play informal roles as counsellors. Illustrative quotations include:

*They come because they feel comfortable in and want a Jewish resource and I'm not statutory so I can be a bit more approachable, where they feel safe and confidential... there is a real fear of being 'found out'.*

*She is schizophrenic. When she comes here [Sikh temple] she is fine, she is included in the prayers. She will not be talked down to, she feels part of the group.*

*As an Imam, so many people come to me, especially with jobless and financial problems. They are really depressed and we advise them to pray. We try to help them with readings from the Qur'an. We advise them to be patient.*

*Had they not been a Muslim, some of the people I have seen are convinced that they would have taken their life.*

*Someone who was bipolar wanted something to occupy her, she has some skills, is using them, realises she can make a positive contribution. I see her each week, we have a little session where she tells me what's happening to her and she feels that she can contribute.*

*The family becomes very close-knit, sometimes you can't separate the family from the person; you have to work very holistically... We are very much aware of how the label of mental illness on one person affects everybody.*

## 2) Stigma and Shame

Guilt and shame about mental illness mean some will not seek help from their faith community. Others feel more comfortable seeking help from their faith community than statutory services. Stigma and fear cause misinformation about psychiatric services and prevent open discussion of mental illness compared to physical disease. Many are surprised by how common mental illness is, because it is so infrequently discussed.

*Why should you go to the church? I feel bad enough about myself already. If you don't achieve the ideals we're encouraged to aspire to, you feel guilty.*

*I remember my mother telling me in India that there is no such thing as mental illness. People... were put on massive ice slabs or given electric shock treatment.*

*We have a stigma in Sri Lanka. Other people in the family suffer. If you break a hand you gladly show it. With the mind we do not recognise, it is hidden. This comes from our society, our culture. Family will keep quiet. Do not want it to get out.*

*I never thought the percentage was this very high, we never hear about mental issues. We need to be made more aware of them. We need to address this in a mosque.*

*Women's depression is hidden and silent.*

*In the Asian community we don't talk about it... Ignorance, pride, fear of it – if you don't know what it is you are afraid of it.*

These quotations emphasise the challenge to services in being approachable for all and encouraging early help seeking. Ethnic minority groups discussed specific sources of fear, which hold them back from disclosing mental illness.

### **3) Mental Health training**

Many faith workers were unsure how to recognise mental illness among their congregants and how to support them. They wanted to be more confident in referral so they could encourage use of services. They wanted training from their own community and service users that includes preventative measures, particularly with young people and substance misuse.

*One of our members is now in hospital. I didn't see the symptoms so I need to be aware of what to look out for and where to get help. I am happy recognising depression but with other problems I'm not so sure.*

*How do you convince them that they need to be referred, in your own language?*

*We should look at how to integrate the mental health services with the spiritual aspect. We can give the real mental support. We need to look at the preventative side. We need to educate the young community to prevent the mental health problems. All of us can contribute a lot.*

*A huge area for me is young people. I referred a 24 year old yesterday, supposed bipolar disorder on a cocktail of medication; what can I really offer him? What is available in the community to not be institutionalised?*

*A year down the line... the daughter has gone into a very depressed state. We should have realised sooner but we missed the daughter because we were so concerned with the dying mother. I think some form of very basic training... would be very beneficial.*



#### **4) The Need for Education**

Faith workers felt training must include basic information they could disseminate to their communities. They need to know what services are available and how to navigate them, to reduce misinformation. Their communities needed education to reduce fear of psychiatric illness and treatment.

*Depression sometimes does not have an outward sign. People say: "What are you talking about? You look all right." The first hurdle is it isn't visible.*

*In most of the Asian countries, we have just one or two words that refer to mental illness. There is no such thing as 'depression' in Bengali language.*

*In a lot of parents I encounter there's a lot of frustration. They are exasperated, but afraid because once the child's labelled within the [mental health] system, there's no way out.*

*There needs to be education, for example [there are] people who try to beat Jinn [spirits] out of people.*

#### **5) Sign-posting**

Participants were aware of the limitations of their support. They identified a key role for themselves in showing understanding, referring to statutory and voluntary services and offering spiritual solace where appropriate (including traditional medicines). They wanted to know how to refer quickly and efficiently without being repeatedly re-referred elsewhere.

*It is dangerous as a minister to think you can help everybody. Friendship and spiritual guidance are fine but you need to refer to professionals. We can only do so much. It is common for clergy members themselves to break down... because they take on everybody's burdens.*

*Our monk may recognise when it is more than just spiritual guidance that is necessary; he can also refer to traditional Ayurvedic practitioners.*

*[On] first impression the Imam will try to help with spiritual [needs, but you are] coming to an institute which cannot be equipped to deal with depression and anxiety.*

#### **6) Spirits and Possession**

Alternative beliefs about the cause of mental illness, including possession and curses, were prevalent within Redbridge's ethnic minority faith communities and in some cases, prevented help seeking.

*My brother was suffering from anxiety; the first thing everyone said was that he was possessed. People need to be made aware that there is depression, anxiety and that it is not possession. It is not always Jinn [spirits].*

*Muslims talk about Jinn. It is hard to describe this to an atheist. Muslims want someone who understands their language and faith.*

*There are a lot of adverts in the local newspapers, which abuse vulnerable people by offering black magic, healing and so on. People are so weak and have a small mental problem; this is when the Imam [must] make people aware of con artists.*

## **7) Services provided by Faith Groups**

Faith communities are flexible, providing services in different languages, organising groups and clubs and offering some therapies, proactively achieving much with few resources. Collaboration between different faiths working towards the same goal is evidence of the creativity and enthusiasm within the faith sector, under-utilised by mental health services.

*Clubs and groups help people get back their self-esteem so maybe they won't need all the pills.*

*We used to have a CBT therapist. We're getting a consultant to set up a [CBT] computer programme, which people are accessing. There are two groups where trained volunteers help people with bereavement and divorce serving the whole Redbridge Jewish Community; it's been running now for 21 years.*

*Drugline [a Jewish organisation] now has a partnership with the Muslim community. It has been very successful... It might be extended to other faith groups in the area.*

## **8) Partnership with Services**

Faith workers felt strongly that there was scope for joint working with statutory services but struggled to establish links. There is an important role for faith groups in training mental health workers in cultural and spiritual awareness but also for mental health workers in training the faith sector.

*You need to cater for that community by employing Imams. Patients bring their children or friends to interpret and the children are too embarrassed to translate correctly, or do not translate correctly.*

*Some of us who are Muslim think that the Western medical model is not appropriate in terms of categorisation of illnesses and it needs to be more holistic.*

Importantly, it was suggested that the Muslim community could take a role in training healthcare workers in basic and relevant aspects of Islam, for example assisting with the Trust's cultural competence training.

## **9) Culturally Sensitive Services**

Some participants felt that only clinicians from their own cultural or spiritual background could understand their needs. This implicates an intermediary role for faith workers to refer people to statutory services by explaining the system and clarifying accessibility, such as the availability of interpreters.

*Muslims almost exclusively want a Muslim professional... Muslims will use Jinn – black magic – and people find it quite difficult to relate to an atheist.*

## **10) Specific Challenges**

Faith workers identified a range of challenges facing their congregants' mental health. These included the pressures of modern life, for the working generation and the elderly, family problems, forced marriage, loneliness and isolation, language difficulties and substance misuse. For faith workers, there was a great challenge in supporting a growing population with such limited resources.

*Modern life is so much pressure – you will not find many mentally disordered in a small village in the country. There is pressure from the work, the telly, see the advertisements on the TV. No-one is satisfied any more.*

*Forced marriage is a big issue. You are expected to marry a Sikh. Your daughter in law is expected to have sons – it can create anxiety.*

*With Asian people there is comparison: "If he has got it I want it too. If he has a bigger house, I want a bigger house. I want to be one better than you". Jealousy, envy.*

*Older people can't get out and about. Language makes it very hard. They rely on the children. The children do not have time, do not spend time with them: "We work all day." It is like prison here for older people.*

*I know someone who is 18 who has depression. It becomes very hard to take the person away from a 'bad' environment if the in-group is taking alcohol and drugs.*

## **Discussion and Recommendations**

These focus groups demonstrate the enthusiasm, interest and need for mental health training in the faith sector. They highlight the significant role already played by faith communities in promoting mental health and the very real scope for care pathways between faith organisations and services. Training presents a simple, cost-

effective and valuable opportunity to work towards genuine equality in mental healthcare, for all.

Mental health training is recommended for faith leaders from spiritual groups represented in the borough's population. Training should develop the capabilities of faith workers in understanding mental illness and the needs of their communities. Training should cover:

- Common psychiatric disorders and how they present.
- How to help a person in crisis.
- The prevalence of mental illnesses.
- How services work, are accessed, according to patients and practitioners.
- When professional referral is needed and how.
- Tackling stigma and discrimination.
- Working with young people and positive prevention.
- Increasing mental health awareness in the community.
- Reconciling belief in possession with seeking psychiatric treatment.
- How to cope with distressing experiences when supporting others.

Training should allow clinicians to interact with faith workers, to encourage partnership and sharing of skills. At senior management levels of the mental health Trust, Primary Care Trust and Local Implementation Team, direct care pathways should be developed between faith communities and Community Mental Health Teams.

After training, an event should bring together all stakeholders from faith and statutory sectors, to share what was learned and evaluate the training. After three months, all participants should be surveyed to determine it's the training's outcomes. If effective, training should be rolled out to additional faith workers and a 'train the trainers' programme, allowing the community to spread awareness, should be explored.

## **Outcome**

This local research identified a need for education, information and training on mental health in the faith sector, as well as formalised referral pathways, to combat fear, guilt and stigma that deter help-seeking<sup>39</sup>. It led to the implementation of a six day mental health training course with 77 Redbridge faith leaders in 2010. The course covered common mental health problems, pathways to local services, listening skills, assertiveness, setting boundaries, the Mental Health Act, treatment, prevention and substance misuse.

The first intervention of its kind in the borough, the training was highly rated by participants, with high rates of attendance and completion, participation and openness<sup>40</sup>. Participants said:

*The course... has given me useful information and tools to support those looking to me, where the Islamic Community is not fully aware of the services and support available, but is keen to turn to leaders who will keep their confidence and guide with spiritual meaning.*

*This course has been very good for the Hindu community; it will support us to live healthier, happier and more meaningful lives. The knowledge of local referral routes to specialist support from the NHS and elsewhere will allow me to help community members to secure appropriate services.*

Subsequently, a Black and Minority Ethnic mental health forum was proposed, where faith leaders can discuss issues affecting their congregants and communicate these to mental health commissioners. A network of mental health Trust clinicians and faith community leaders is also being discussed, which would ensure long-term partnership between community and statutory services for networking, updating and delivering further training.

A workshop held with mental health Trust staff in 2011 identified awareness within the statutory sector of the need to support patients' spiritual needs. Priorities for staff were policy and training to ensure consistent spiritual needs assessment, prioritisation of spirituality by the Trust, the clinical environment as an under-used and cost-effective tool to enhance spiritual experiences and the need for basic mental health training for community faith leaders. Staff requested partnership with the voluntary sector: evidence that the desire for joined-up working is mutual, in both sectors.

## **Conclusion**

This paper describes local, national and research evidence supporting the role of spirituality in mental health and recovery. It outlines the rationale, findings and implications of a small-scale study of faith leaders in an ethnically and spiritually diverse London borough. It reveals that, despite the complexity of the issue, there is great potential for interventions that harness existing networks of enthusiastic practitioners in community and statutory sectors. The positive outcome of the mental health training recommended by this research illustrates the potential to make radical changes to community education with low-budget explorations of local priorities. Mental health services in increasingly diverse boroughs must address spirituality if they are to deliver truly patient-centred care. This project shows how, despite budget constraints, meaningful change can be made to enhance prevention and early intervention, reduce stigma and misinformation – all towards achieving genuine health equality.

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## Appendix 1: Participant Information Sheet



### Mental Health Focus Groups Information Sheet

#### Introduction

Redbridge Faith Forum has obtained a small grant from the London Borough of Redbridge to conduct a series of seminars, workshops and training sessions for faith leaders on mental health issues.

#### Background

Research indicates that religious communities and individuals are reluctant to use mainstream psychiatric services. The literature also suggests that religious leaders are overwhelmed with pastoral and counselling work and that they would welcome more professional support and they do and would refer for professional help.

#### What are the aims of the focus group?

1. To find out the views, opinions and experiences of faith leaders and congregants with regards to mental illness and mental health.
2. To find out the needs of faith leaders with regards to mental health training
3. To engage with faith communities in order to capture their understanding of the challenges they face; and the actions that would help in overcoming them.
4. To use the information and ideas to design a mental health training programme

#### What will happen to the results of the focus groups?

A report will be written up and presented to the Redbridge Mental Health Partnership Planning Group Redbridge NSF Local Implementation Team (LIT) and will be used to plan and deliver a mental health training course.

**Remit of the LIT:** The LIT provides strategic direction and is responsible for overseeing services for adults with mental illness. The LIT ensure that services are commissioned, delivered, monitored and evaluated through an effective partnership of all relevant agencies. It ensures that the National Service Framework for Mental Health is implemented in the London Borough of Redbridge according to Government guidelines.



## **How will your privacy be protected?**

Every effort will be taken to protect your identity as a participant in this study. You will not be identified in any report or its results.

## **Appendix 2: 'Mental Health in Redbridge' focus group Introductory presentation statistics**

There is no health without mental health.  
At any one time, one adult in six suffers from a mental health problem.  
Over 30,000 men and women in Redbridge.

### **Older People**

Approximately 1 person in 50 aged between 65 and 70 has dementia.  
60% of acute hospital inpatients over 65 years of age will have a mental health problem.  
Significant depression is present in 15% of older people.

### **Children and Young People**

In Redbridge there are over 32,000 children between the ages of 5 and 14.  
Over 3000 of them are likely to have a mental health problem.  
In young people depression and low self-esteem are linked with smoking, binge drinking, eating disorders and unsafe sex.  
Suicide is still the biggest cause of death in young men.

### **Depression and Anxiety**

It is suggested that more than half of those who attend their GP may have some symptom of depression.  
60 to 70% of adults will at some time in their lives experience depression or worry of sufficient severity to influence their daily activities.  
By 2020 depression will be only second to chronic heart disease as an international health burden.  
Strong evidence establishes depression as a risk factor for heart disease.  
One in 10 people are likely to suffer from disabling anxiety at some stage in their life.

### **Some Facts**

It is estimated that nearly 3 in every 10 employees will experience a mental health problem in any one year.  
According to the Royal College of Psychiatry: 1 in 5 people recover completely.  
Only 24% of adults with long term mental health problems are in work.  
Only 40% of employers say they would employ someone with a mental illness.  
Research shows that many of us learn about mental illness through the media.

### **Stigma and Discrimination**

The Sun: "Bonkers Bruno locked up."  
The Daily Mail: "Knife maniac freed to kill. Mental Patient ran amok in the Park."  
The Sun: "Violent, Mad. So Docs set him Free."

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Final year student, graduate/profession entry programme MBBS

Kings College London