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# Sensitising Mental Health Professionals to Islam

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## Summary of project:

Based on recent local and global events, and identified local clinical needs of our in-patient Muslim population, this project was conducted on five psychiatric admission wards, at the Huntley Centre, a hospital site in Camden & Islington Mental Health & Social Care Trust. The project aimed to enhance the knowledge base about mental health aspects of Islam among clinicians and administrative staff through an educational intervention, translate this into guidelines for culturally sensitive care for the Islamic population, and revise the general policy on in-patient care across all ethnic groups. Following a literature search and preliminary clinical ethnographic fieldwork, a semi-structured questionnaire was developed to specifically assess staff knowledge on Islam as applied to clinical psychiatric care, before and after a day long targeted intervention workshop. The project resulted in an improvement of staff knowledge on Islam, enhanced care for this group of patients, and the formulation of good practice policy on cultural dimensions of care for Muslim in-patients. The momentum generated by this project led to an established post of a lead cross-cultural nurse, and facilitated the development of a cross-cultural programme on one of the acute clinical units.

## Background

Islam is both a religion and a culture that influences the everyday life of its adherents. There are 900 million followers of Islam worldwide, of which 1.6 million reside in the UK (OPCS census, 2001), and comprise the second largest patient group being admitted to our hospital. Published literature suggests individuals from black and ethnic minority groups in Britain are likely to receive worse healthcare than many of the white population (Ahmed, 1993; Hussain, 2001). Despite pleas from service users and the local Muslim community for mental health professionals to take into account their religious and spiritual needs (Rose, 2001; C & I MHSC NHS Trust, 2003), literature suggests NHS mental health services fail to meet such needs (Greasley at al., 2001). This is not

surprising as mental health professionals receive scant training on how religion may influence an individual's experience and expression of suffering (Narayanasamy, 1993, 1995). Additionally, recent global events, such as the bombing of the World Trade Centre, subsequent persecution of Muslims, an assumption that there was a 'clash of civilisations' (Huntington, 2002), together with local demands of our hospital nursing staff, motivated this project.

## Aims

- Enhance mental health professionals' knowledge of Islamic cultures
- Develop guidelines on culturally sensitive care for Muslim in-patients in a mental health setting

## Objectives

- Elicit mental health professionals' current knowledge of Islam and mental health
- Provide training to improve knowledge on Islam and mental health
- Enhance understanding on experience of Muslim in-patients in a mental health setting
- Develop guidelines for working with Muslim in-patients in a mental health setting
- Develop policy for sustaining culturally sensitive care across all ethnic groups

## Method

Two project workers (proficient in Islam) were appointed through a nationally advertised competitive interview, to work one day a week with the project leaders for a period of one year. Initially, an extensive literature review on Islam and mental health was conducted. This review, together with clinical ethnographic fieldwork at the Huntley Centre; consultations with several local, national, international scholars in the field of cultural psychiatry, religion, and social anthropology; Muslim service users; and the Trust employed Imam, guided the development of a semi-structured questionnaire – The Islam & Mental Health Knowledge Questionnaire (IMHKQ). The questionnaire consisted of 54 true/false propositions and several open-ended questions. Examples of the true/false statements include:

- The sacred text for Muslims is the *Taliban*
- A *Fatwa* is a death sentence
- Most Bangladeshi's speak Urdu
- *Begum* is a Muslim family name
- Suicide is not prohibited in Islam
- Muslims may eat *Kosher* food
- Most Bangladeshi's speak *Urdu*

The IMHKQ was used to elicit staff knowledge on Islam and mental health matters prior to targeted training.

# FOCUS

The IMHKQ was also administered to a control group from the Human Resources Department, University College London.

A tailored day long workshop was subsequently conducted at the Regent's Park Mosque for each of the five mental health teams. The programme for the workshop covered issues such as:

- What is Islam?
- Who are Muslims?
- Outline of Islamic Sects
- Gender issues in Islam
- Islam & Sexuality
- The Unseen and Spirit Possession
- Clinical issues in the diagnosis and management of Muslim in-patients

All workshop participants were provided with lecture handouts, background reading, together with an authoritative English translation of the Qur'an. Participants were also requested to complete an anonymous written evaluation of the workshop. The impact of this workshop was objectively measured on the IMHKQ, six weeks after the training event. Additionally, in an effort to audit the impact of the workshop intervention, Muslim in-patients were interviewed on their experience as in-patients at the Huntley Centre.

The quantitative data was analysed using the SPSS. Qualitative data obtained from the IMHKQ, patient interviews and field notes, was content analysed by the project workers.

## Findings

63% (N=81) of staff attended the training workshop at the Regent's Park Mosque.

**Table 1. Demographic characteristics of the sample who completed the IMHKQ**

	Pre-workshop N=46	Post-workshop N=38
Numbers (%) male	23 (51)	22 (58)
Mean age in years (SD)	35.8 (8.8)	37.5 (9.6)
<b>Ethnicity N(%)</b>		
White Europeans	21 (50)	16 (44)
Black UK	2 (5)	2 (6)
Black African	14 (33)	12 (33)
South Asian and others	5 (12)	6 (17)
Median time employed by Trust (range)	2.25 yrs (3wks-30yrs)	2yrs (8wks-30yrs)
<b>Discipline</b>		
Admin	3	
Healthcare	3	1
Mental health	10	2
Nursing	14	9
Occupational therapist	4	15
Pharmacist	1	1
Psychiatrist	4	0
Psychologist	1	3
RMN	3	1
<b>Religion N(%)</b>		
Christian	29 (66)	25 (69)
Muslim	5 (11)	4 (11)
Hindu	1 (2)	2 (6)
Jewish	1 (2)	0
None	8 (18)	5 (14)
Median no. of Muslims cared for in last year (range)	8 (0-100)	8.5 (0-50)

## Knowledge about Islam – Quantitative findings

Demographic characteristics of the sample who completed the IMHKQ is shown in Table 1. Pre response rate on IMHKQ 36.8% and post response rate was 30.4%.

Quantitative analysis of pre and post workshop IMHKQ suggested an improvement in correct response on 63.5% of the 52 items. Four items showed a statistically significant improvement ( $p < 0.01$ , Fischer's exact test).

The project team subsequently identified 24 core questions from the IMHKQ that were thought 'essential' knowledge for providing routine clinical care for Muslim in-patients. Analysis of true/false responses on this pre- and post-intervention sub-set revealed an improvement on 50% of these items.

Further analysis to control for confounding variables such as age, length of service, and duration of professional contact with Muslim patients on questionnaire scores did not show any significant differences. Similarly, a factor analysis of response to all 52 items did not reveal any homogenous categories.

## Staff knowledge about Islam – Qualitative findings

Content analysis revealed the following major themes identified by staff in relation to caring for Muslim patients: confusion over providing a Halal diet, prayer times, facilities and availability of the Holy Qur'an, confusion over administering medication during Ramadaan, subordinate status of Muslim women and the gendered stigma of mental illness, language and communication difficulties, and the lack of appropriate washing facilities on the ward.

Although over half the sample felt their ward was sensitive to the needs of Muslim patients and other ethnic minorities, there was acknowledgement that more could be done. Space limits detailing narratives that illustrate a range of issues.

## Patient group

Six patients were interviewed individually about their experience pre and post intervention on the in-patient psychiatric wards. The majority interviewed spoke of the benefits associated with reading and reciting the Qur'an, being able to pray on the ward and being visited by the Hospital Imaam. The provision of a varied Halal diet was most frequently highlighted as a specific issue about care on the ward. When asked whether clinicians had addressed any link between their religion and personal suffering, all 6 subjects stated that they had not. Yet in some cases, Muslim patients had had discussions about religion with fellow patients. In response to queries on matching staff with patients' gender, most subjects did not object, stating that all they wanted was appropriate care.

## Control group

The IMHKQ was administered to a control group ( $n = 14$ ), who did not attend the training intervention, and were chosen because they were a convenient to access non-mental health professional group. All of them were non-clinical staff from the Human Resource Department at University College London. Most were white Britons, with post-graduate degree qualifications (mean age 37 years).

# FINDINGS

The researchers had hypothesised clinical staff would perform better than the control group, as they had more exposure to mental health problems of the local Muslim community and were expected to provide culturally sensitive care.

Results show no significant difference between staff and control group except on one item (Islam is the oldest of all religions), where staff knowledge scores were higher than controls ( $p < 0.001$ , Fisher's exact test).

## Discussion

Staff welcomed the opportunity to attend their training day at the local Mosque. The workshop discussions were enthusiastic and lively. Although attendance was voluntary, over 60% attended. This indicated a high staff motivation. Attendance of all administrative and secretarial staff was also encouraging. The latter group was crucial to this project as they are involved with typing patient summaries, handling telephone enquiries, and resourcing/staffing the hospital reception. Recruiting agency nursing staff to cover each sector ward, awarding 8 CPD points for attendance, and provision of free car parking enabled high staff attendance.

There were several gains from holding the workshop within a Mosque. The very experience of entering and spending a whole day at the Mosque was a novel experience for most participants. Other enabling activities such as eating a Halal meal and watching or attending prayers gave staff an idea on various day to day activities of Muslims. Several participants commented that it was a calm place and would benefit in-patients attending the Mosque if they were provided with a nurse escort.

Results from pre and post workshop IMHKQ scores suggest training did not significantly improve staff knowledge. In fact, post-workshop scores were lower on certain items of the IMHKQ. It is not clear why this was the case although this mirrored the control group response, and may relate to the ambiguity of some items on the IMHKQ.

The questionnaire had two response categories "True" and "False", with a 50% probability of correct response on each item. The response rate pre-workshop may be indicative of the number of correct "guesses" the respondents made to the items, whereas the response rate post-workshop may be based on actual knowledge. The introduction of a third category "Don't know" could have prevented guessing, and reduced false positive scores on the pre-workshop assessment.

It is also possible that the study subjects had sufficient knowledge of Islam prior to the workshop. In fact, if an arbitrary cut off of 50% correct response on each item is considered for the purpose of this analysis, the pre-workshop scores suggest that more than 80% of items were answered correctly. More significantly, scores after the workshop improved to the 50% cut off (correct response), on all except five items. It is crucial to note that the project team have chosen an arbitrary cut off of 50% as the questionnaire has not been validated on the

general Muslim population to establish an average base line score against which the study sample could be compared. It would have been ideal to have a second control group comprising of Muslims from the local community for this purpose.

The investigators had hypothesised that clinical staff would know more about Islam and mental health matters since they work with a significant number of Muslim patients. This was not the case and therefore suggests staff receive very little training on cultural dimensions of mental health.

One of the major challenges for public health professionals and related disciplines, particularly on projects aimed at intervention, education and communication activities is to tease out the difference between what people say and what they actually do. This study focussed on what staff said in response to several questions, but the study could not follow it up with assessment of its impact on actual attitude and behaviour on the ward. Thus is it possible that sufficient knowledge of Islam might not be the sole determinant on how well Muslim patients are cared on the ward. Attitude and skills also play a major role in caring. This might explain why none of the staff had discussed religion with the patient group. Additionally, religion is one amongst the several variables that comprise culturally sensitive care. Other aspects such as gender, language spoken, social class, skin colour, country of origin of both patients and staff, might elicit differing response in routine clinical care. These issues, together with the workshop experience, indicate the damaging consequences of stereotyping a diverse Muslim patient population on the basis of their religion alone. Islam may well play a major role in shaping Muslim patients' cultural identity, but it is crucial that patients are asked rather than judged on the basis of a clinician's personal knowledge of Islam.

One of the main limitations of the project is the small sample size of both the staff and the control group. Additionally, whilst the study attempted to measure staff knowledge, it did not measure staff attitudes and behaviour. Funding constraints precluded more patient interviews and prohibited further follow up training sessions for staff. The latter might have enabled staff to reflect on their clinical practice, and helped clarify the extent to which mental health professionals changed their clinical practice with this patient group over a period of time.

This project did lead to several other tangible gains that were critical for the development of a culturally sensitive clinical service in the hospital. These include constitution of a multi-faith group within the Trust, creation of a nationally unique post of cross-cultural lead nurse on one of the acute care wards, and the development of policy for culturally sensitive care for all ethnic groups. Local, national and international dissemination of this project resulted in an expression of interest for similar training in diverse health settings. Currently, the investigators are in the process of validating the IMHKQ on the local Muslim population. Future plans include the development of a

fully-fledged programme in cultural psychiatry on a psychiatric intensive care unit to include policy, service, training, and research dimensions; and aim at a show case model of good practice in the field.

## Conclusion

The aims and objectives of this project were to elicit mental health professionals' knowledge of Islam and mental health, to provide clinicians with the opportunity to reflect on their current practice with Muslim patients, and to improve staff knowledge in this area following an educational workshop. In addition, the project aimed to clarify the experiences of Muslim patients who had been admitted to psychiatric in-patient units. All were achieved. As a result of this project, clinical teams are now working more closely with the hospital Imam and showing greater interest in religious and spiritual needs of patients and their carers. Further more, staff enjoyed attending the workshops and have expressed a need for training on other religions. However, despite this, the challenge to ensure that individual patients who come from diverse cultural backgrounds receive clinical care that is culturally relevant to them still remains for this Trust and other healthcare providers. Enthusiastic but challenging initiatives, conducted on limited funding may well be part of the answer.

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