

THE FEDERATION OF STUDENT ISLAMIC SOCIETIES PROGRAMME TO CHALLENGE MENTAL HEALTH STIGMA IN MUSLIM COMMUNITIES IN SCOTLAND: THE FOSIS GLASGOW STUDY

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SUMMARY

Introduction: A recent study commissioned by the Scottish Government on the prevalence of mental disorders in Muslims in Scotland revealed that over 50% of the sample met the diagnostic criteria for a mental illness. Stigma is a major barrier to mental health services and despite the availability of effective treatment, many Muslims in Scotland with mental health difficulties continue to suffer in silence. The Federation of Student Islamic Societies (FOSIS) Scotland branch organized a mental health conference in Glasgow to improve Mental Health Literacy and challenge mental health related stigma in the Scottish Muslim community. The conference was comprised of: A counsellor with a background of Islamic psychology, a psychiatrist and an Imam (a Muslim religious leader).

Design: We conducted a single-arm, pre- post- comparison study on Muslims who attended the FOSIS mental health conference in Glasgow, Scotland. Validated psychometric stigma scales measuring knowledge (Mental Health Knowledge Schedule (MAKS)), attitudes (Community Attitudes towards the Mentally Ill (CAMI)) and behaviours (Reported and Intended Behaviour Scale (RIBS)) were administered on participants before and immediately after exposure to the programme.

Results: 34 out of the 55 participants who attended the conference responded (response rate 62%). 34/34 (100%) of the respondents were Muslim and the mean age was 22.7 years (Std. Dev. 6.04, min. 18, max. 49). There were no statistically significant changes in stigma across the domains of knowledge, attitude and behaviour in respondents following exposure to the event.

Conclusion: Previous FOSIS anti-stigma conferences in England and Ireland featuring an Expert by Lived Experience were associated with statistically significant reductions in mental health related stigma. The results of the FOSIS Glasgow study supports the, 'Power of contact' with an Expert by Lived Experience at reducing mental health related stigma in the Muslim community. More robust research in this area is urgently required.

Key words: mental health stigma – mental illness – Muslim community – Islamophobia – Expert by Lived Experience

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INTRODUCTION

According to the National Records of Scotland, as of June 2018 the estimated population of Scotland is 5,438,100 (Scottish Government 2018). More than one in three people in Scotland are estimated to be affected by a mental health problem (Scottish Government 2018). The Scottish Government has recently launched a ten-year mental health strategy in order to tackle the rising numbers of individuals affected by mental health disorders. The approach mainly focuses on prevention and early intervention, access to treatment and services and the physical well-being of individuals with mental health problems. The overall aim is to create a stigma-free environment and focus on patient-centred mental healthcare. As a result, several actions have been taken

by the Scottish Government which include increasing the mental health workforce by 800 within primary care, secondary care, police stations, schools and prisons; reviewing counselling services in educational establishments and creating an emphasis on prevention within the Child and Adolescent Mental Health Services (Scottish Government 2018).

Muslim population in Scotland

The Second World War marked the point at which the Muslim population grew not only in Scotland but around the whole of the UK (Scottish Government 2018). There are 75,300 Muslims in Scotland which constitutes approximately 1% of the total population (Scottish Government 2018). The prevalence of mental

health issues amongst Muslims in Scotland was examined in a study commissioned by the Scottish Government. The study showed that 35.6% (n=79) met the criteria for a mild mental illness whilst 13.6% (n=30) were found to suffer from a more serious form of mental illness (Hussain 2009).

Mental health related stigma in Scotland

The most well-known and accepted definition of stigma was produced by Goffman in his acclaimed work, “Stigma: Notes on the Management of Spoiled Identity”. In his work Goffman defines stigma as, “A deeply discrediting attribute that reduces the bearer from a whole a usual person to a tainted and discounted one. The individual is thus disqualified from full social acceptance” (Goffman 1963).

Generally, there are two types of stigma related to mental health: social/public stigma and self-stigma (Haddad et al. 2015, Zaman et al. 2018). Social stigma refers to negative perceptions and stereotypes of people suffering from poor mental health. Self-stigma results from the internalisation of social stigma. Self-stigma cultivates feelings of inadequacy, hopelessness and low self-esteem which can inevitably result in further deterioration of mental illness. Stigma presents persistent and serious challenges that have negative implications on numerous domains of a person’s life ranging from health to income (Yang et al. 2017). Stigma is a formidable barrier to mental health services and consequently many people with mental illness continue to suffer in silence despite the availability of effective treatment (Sartorius 2007).

Mental health related stigma is rampant in Scottish society. Over one third of people in Scotland who suffer from mental health problems report experiencing stigma and discrimination and being impacted by it (SAMH 2017).

“See Me” is Scotland's National Programme to tackle mental health related stigma and discrimination. “See Me” are funded by the Scottish Government and Comic Relief and are managed by SAMH and The Mental Health Foundation (<https://www.seemescotland.org/about-see-me/>).

“See Me’s” mission is:

- To mobilise people to work together and lead a movement to end mental health related stigma and discrimination.
- To work with people to change negative behaviour towards those with mental health problems.
- To ensure that the human rights of people with mental health problems are respected and upheld (<https://www.seemescotland.org/about-see-me/>).

Mehta et al. analysed trends in public attitudes towards people with mental illness in England and Scotland using Department of Health Attitudes to Mental Illness Surveys, 1994-2003. Comparing 2000 and

2003, they revealed that there was significant deterioration for 17 out of 25 (68%) of the items on the surveys in England and for 4 out of 25 (16%) of the items in Scotland. Neither country showed significant improvements in items between 2000 and 2003. Mehta et al. conclude that public attitudes towards people with mental illness in England and Scotland became less positive during 1994-2003, especially in 2000-2003, and to a greater extent in England. They posit that the results were consistent with early positive effects for the 'see me' anti-stigma campaign in Scotland (Mehta et al. 2009).

Islamophobia and Psychological Distress amongst Muslims

The 9/11 terror attacks in the United States of America heralded the beginning of a dramatic change in the quality of life for most Muslims living in the West (Hankir et al. 2017a). Following the attack, Islamophobia, a form of discrimination rooted in racism, became more prevalent, seeping into everyday conversation as well as the media (Sheridan, 2006). Research indicates that there has been increased hostility towards Muslims by non-Muslims in the United States. This parallels the increasing anti-Muslim discourse by politicians and media outlets. Compilation of Islamophobic hate crimes by the Council on American-Islamic Relations (CAIR) explicitly shows that between 2014 and 2016, anti-Muslim bias incidents rose by 65% (CAIR 2017).

Islamophobic hate crimes are by no means limited to the United States and occur throughout the West (Hankir et al. 2017a). Recent studies have clearly illustrated the stark positive correlation between incidences of Islamophobic attacks and the increase in anxiety and psychological distress experienced by Muslims (Kunst et al. 2013). Islamophobia can also exacerbate pre-existing mental illness (Hankir et al. 2015).

The media’s biased portrayal of Muslims has fuelled the feeling of ‘otherness’ between Muslim communities and the rest of society (Shaver et al. 2017). Additionally, some of the stringent measures integrated into society in an attempt to prevent a reoccurrence of 9/11, such as counter-terrorism laws and Schedule 7, has only served to heighten the sense of alienation Muslims feel within their community. A recent study showed that Pakistanis and Bengalis believe that they are treated in a harsher manner by police compared to their Caucasian counterparts. This has led to Muslim youth viewing law enforcement with increased tension, anxiety and hostility (Choudhury et al. 2011).

In a society already plagued by stigma pertaining to mental health, the feeling of “otherness” only serves to further marginalise those within the Muslim community who are suffering from mental illness. This intersectionality (i.e. the stigma attached to being a Muslim and the stigma attached to mental illness) is known as, ‘Double-stigma’ in the literature (Ciftci et al. 2013).

Mental health literacy

Anthony Jorm coined the term Mental Health Literacy (MHL) in 1997 and defined it as, "Knowledge and beliefs about mental disorders which aid their recognition, management or prevention". Components of MHL include: the ability to recognise different types of psychological distress; knowledge and beliefs about risk factors and causes; self-help interventions; professional help interventions; how to seek mental health information and attitudes which facilitate recognition and appropriate help-seeking (Ahmedani 2011). Mental health literacy is a concept many anti-stigma campaigns use to promote mental health awareness (Rüsch et al. 2005).

Although there has been a rise in research on MHL, the existing literature predominantly assesses the MHL of healthcare professional. However, the MHL of the public remains neglected. A recent study on MHL of the public indicated that among 273 patients with anxiety and mood disorders, an average of 7 years was required to identify the problem (Ahmedani 2011). A longitudinal study in Germany conducted in 1993 to 2001 concluded that the recognition of mental disorders by the general public had improved within this time period. In 1993, 17.1% and 26.9% could identify schizophrenia and depression, respectively, which increased to 22.4% and 37.5% in 2001 showing an improvement in MHL (Ahmedani 2011). However, despite an increase in MHL, the desire for social distance from people suffering with depression or schizophrenia remained unchanged (Angermeyer et al. 2009). This supports that notion education alone to improve MHL is not effective at reducing mental health related stigma.

At a governmental level, public interventions and strategies are necessary in order to increase help-seeking behaviours and reduce mental health stigma. This would allow early intervention reducing overall morbidity and mortality associated with poor mental health (Sartorius 2007). Mental health campaigns should be sensitive, specific to the target audience with clear aims and objectives, otherwise they may risk being inadequate.

Generally speaking, there are low-levels of mental health literacy in the Muslim community. American Muslim Health Professionals launched several mental health programs and initiatives to enhance community level capacity to identify mental health issues early on, increase awareness about available resources and support, de-stigmatize mental health illness and improve mental health literacy in families and communities (<https://amhp.us/mental-health/>).

Federation of Student Islamic Societies (FOSIS)

The Federation of Student Islamic Societies (FOSIS) is an umbrella organisation aimed at representing, uniting and supporting student Islamic Societies across the UK and Ireland. FOSIS has been serving Muslim

students since 1963 making it one of the oldest Muslim student organisations in the UK.

On the 3rd of March 2019, FOSIS Scotland organized a conference entitled, 'Let's talk about mental health' in Glasgow, Scotland at the University of Strathclyde. Through a series of lectures and interactive workshops, the one-day conference aimed to increase awareness of mental health, improve MHL and reduce the stigma and misconceptions associated with mental health issues amongst the student Muslim population in Scotland. The conference was targeted at students but was also open to the general public.

With regards to the speakers, the conference invited a counsellor with a background in Islamic psychology, a psychiatrist and an Imam (a Muslim religious leader). These speakers were selected to educate our audience on mental health by addressing three of its elements: the psychological, physical and spiritual respectively.

STUDY DESIGN

We conducted a single-arm, pre- post- comparison study on participants who attended the FOSIS Scotland, 'Let's talk about mental health' conference. Validated psychometric stigma scales on knowledge, attitudes and behaviour were administered on participants before and immediately after exposure to the intervention. Muslims who attended the conference were recruited to participate in the study. The study was explained during the introductory lecture and verbal consent was obtained. The questionnaires were printed in paper format for attendees to complete due to previous studies indicating that this improves response rate (Hankir 2014) (Figure 1).

Measures

Three measures were used in this study to assess stigma and discrimination:

- Mental Health Knowledge Schedule (MAKS)
- Reported and Intended Behaviour Scales (RIBS)
- Community Attitudes to the Mentally Ill (CAMI)

These are self-administered psychometric scales of mental health knowledge, attitudes and behaviour in the form of a questionnaire scored on a five-point Likert scale. Each takes 1-2 minutes to complete.

Mental Health Knowledge Scale (MAKS)

MAKS has been designed to measure mental health-related knowledge among the general public and evaluate anti-stigma interventions (Evans-Lacko 2010). It comprised six items (1-6) on stigma-related mental health knowledge areas and six items (7-12) on the classification of various conditions as mental illness. Participants were asked to indicate whether they agreed or disagreed with the items on a five-point Likert scale.



Figure 1. Promotional material used to recruit participants for the FOSIS Glasgow Study

Reported and Intended Behaviour Scales (RIBS)

RIBS has been designed to measure mental health-related behavioural discrimination among the general public and document behavioural trends (Evans-Lacko 2011). It comprised four items (1-4) which assess the prevalence of behaviour and four items (5-8) which on intended behaviour in the same contexts. Participants were asked to indicate whether they agreed or disagreed with items 5-8 on a five-point Likert scale.

Community Attitudes to the Mentally Ill (CAMI)

CAMI has been designed to measure mental health-related attitudes among the general public. Participants were asked to indicate whether they agreed or disagreed with the three statements below on a five-point Likert scale.

One of the main causes of mental illness is a lack of self-discipline and will-power

- There is something about people with mental illness that makes it easy to tell them from normal people;
- It is frightening to think of people with mental problems living in residential neighbourhoods.
- In addition to this, participants were also asked to complete a short form requesting demographic data.

Statistical analysis

The total scores for MAKS, RIBS and CAMI were calculated with higher scores indicating lower levels of stigma. A paired sample t-test for means was conducted to compare pre- intervention and post-intervention scores. Results were considered significant at $p \leq 0.05$.

RESULTS

Although 55 participants attended the conference, 62% (n=34) completed both the pre- and post- stigma scales. 34/34 (100%) Of participants were Muslim.

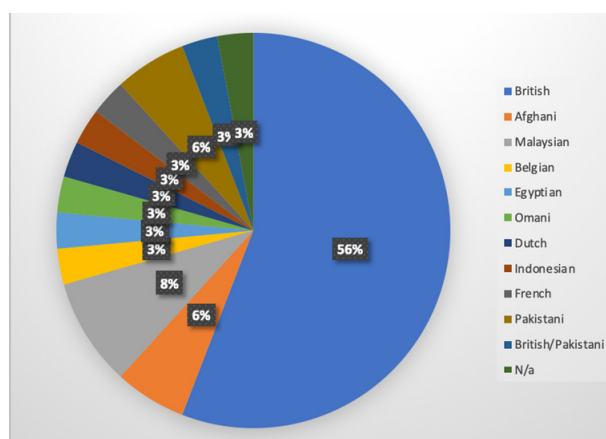


Figure 2. Nationalities of respondents

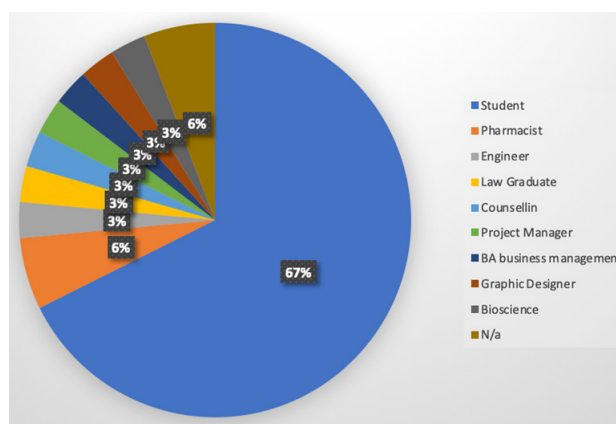


Figure 3. Educational/ occupational background of respondents

The occupational/educational backgrounds and nationality of attendees are represented in figures 2 and 3 respectively. The mean age of participants was 22.7 (Std. Dev. 6.04, min 18, max 49)

The mean pre-RIBS score was 16.91 (Std. Dev. 2.47, 95% Conf. Interval 17.76–16.05) and the mean post-RIBS score was 16.75 (Std. Dev. 3.25, 95% Conf. Interval 17.88–15.62). There was no statistically significant difference in the pre-RIBS score compared to the post-RIBS score ($p=0.7446$) (see figure 4).

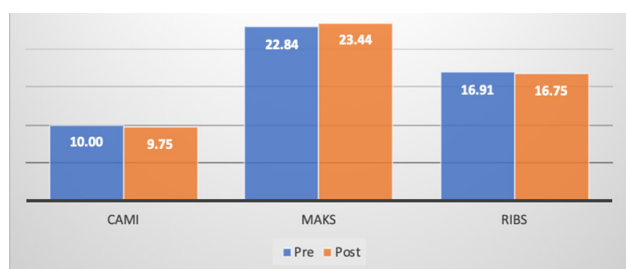


Figure 4. Pre-post scores for CAMI, MAKS and CAMI. (CAMI- Community Attitudes to the Mental Ill, MAKS- Mental Health Knowledge Schedule, RIBS- Reported and Intended Behaviour Scales)

The mean pre-MAKS score was 22.84 (Std. Dev. 2.78, 95% Conf. Interval 23.81–21.88) and the mean post-MAKS score was 23.44 (Std. Dev. 2.27, 95% Conf. Interval 24.22–22.65). There was no statistically significant difference in the pre-MAKS score compared to the post-MAKS score ($p=0.1976$) (see figure 4).

The mean pre-CAMI score was 10.00 (Std. Dev. 1.92, 95% Conf. Interval 10.66–9.34) and the mean post-CAMI score was 9.75 (Std. Dev. 1.83, 95% Conf. Interval 10.66–9.34). There was no statistically significant difference in the pre-CAMI score compared to the post-CAMI score ($p=0.4982$) (see figure 4).

DISCUSSION

As far as the authors are aware, this is the first ever intervention study on challenging mental health related stigma in Muslim communities in Scotland published in the literature. The FOSIS Glasgow study did not show any statistically significant reduction in mental health related stigma in the domains of reported and intended behaviour, attitudes towards the mentally ill and mental health knowledge. This could be due to several factors:

Participants were self-selecting and may have had a previous interest in the topic of mental health. They may already have had a good understanding of mental health issues and low levels of stigma relative to the general Muslim Scottish population. It can therefore be hypothesised that this was a factor that contributed to the results (i.e. that there were no statistically significant changes in scores in respondents following exposure to the conference).

The short duration of the conference could have been a factor affecting the impact of the conference. The one-day event limited the contact time of our audience with the specialists and thus may have hindered the attainment of the full educational impact that this conference could have had.

The statistically insignificant results could also be partly attributable to the intervention itself. Previous FOSIS conferences in Birmingham (Hankir et al. 2017b) and Dublin (Hankir et al. 2017c) included a contact-based, anti-stigma programme, known as, ‘The

Wounded Healer’, delivered by an expert by lived experience, whereas this was not present in the FOSIS Glasgow Study.

The main limitations of our study were the small sample size and the lack of follow up and no control group. A larger sample size, a comparison group and a longitudinal design might help to control for confounding factors. Due to the limitations of our study, our results are not representative, nor generalizable.

CONCLUSION

To the best of our knowledge, the FOSIS Glasgow study is the first intervention study challenging mental health related stigma in the Muslim community in Scotland to be published in the literature. There were no statistically significant reductions in knowledge, attitude and behaviour in participants who attended the event. Previous FOSIS studies held in Birmingham and Dublin (Hankir et al. 2017b, 2017c) supported the, ‘Power of contact’ to reduce mental health related stigma (Corrigan et al. 2012). The results of the FOSIS Glasgow Study suggest that a conference that excludes an expert by lived experience may not be effective at reducing mental health related stigma in the Muslim community. More research in this area is urgently needed.

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Conflict of interest: None to declare.

Contribution of individual authors:

Ahmed Hankir, Frederick R. Carrick & Rashid Zaman conceived the idea of the study, contributed to the literature review and revised the manuscript.

Rafa Abushaala organised the study, collected the data, and contributed to the literature review.

Loubna Kraria & Aleema Sardar collected the data and contributed to the literature review.

Deemah Al-Obaidly collected the data, contributed to the literature review and revised the manuscript.

Sanah Ghafoor revised the manuscript.

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