5

Mental Health Awareness among Imams Serving New Zealand's Muslim Population

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Abstract

As clerical leaders, imams are key members of Muslim communities, and they provide spiritual guidance and advice to Muslims resident in New Zealand, including an increasingly diverse immigrant population. The aims of this study were to ascertain imams' knowledge of and beliefs about mental health and to identify any gaps in their knowledge of local mental health perspectives and services, as well as to explore the role of imams in providing support for individuals and families within the Muslim community who have mental health issues. In their role as leaders, imams provide a type of counselling service to the community and are called upon to offer advice on a range of issues directly related to mental health. In this study, ten imams were interviewed regarding their knowledge of mental health and their role in providing support in this area. Establishing dialogue with imams about local perspectives on mental health would go far toward addressing the mental health needs of Muslim communities by exploring the ways in which mental health training could be incorporated into the imams' own culturally appropriate healing practices.

Keywords: mental health, Muslim community, imams, community services

The earliest Muslim residents of New Zealand comprised 15 Chinese Muslim gold-diggers, whose presence was recorded in the 1874 census. Today, as a result of recent political and economic instability, poverty, and war, the number of Muslim refugees around the world has increased, including those seeking refuge in New Zealand (Refugee Resettlement New Zealand, 2005). The Muslim community living in New Zealand consists of 40-plus different ethnicities, but most would identify themselves as Muslims and relate to one another as Muslims rather than based on their individual ethnicities (Shepard, 2006). The larger Muslim community here is thus made up of a

diversity of smaller communities with some differences in their ways of practising religion, as well as in their resources and needs (Shepard).

Members of Muslim communities attend the mosque on a regular basis for prayers and other religious events. Imams (clerical leaders) are regarded as the most esteemed members of the various Muslim communities and they play an important role in increasing health awareness and counselling other community members (Abu-Ras, Gheith, & Cournos, 2008; Padela, Killawi, Heisler, Demonner, & Fetters, 2010). Imams hold special importance in terms of gaining access to Muslim communities, in the sense that mosques are usually the only place where Muslims come together as one entity. Each ethnicity within the Muslim community has its own leaders and elders who serve as support people for those ethnicities. However, the organisational structure of each community is similar and imams of local mosques are seen as the overall community leaders and respected by all. There are some differences, of course, in the ways that different sects practise their religion, but the religious beliefs behind those differences are the same for all Muslims, for they all follow the same Qur'an and Sunnah (the living example of the prophet Muhammad). Therefore, adopting a more holistic mental health approach to research in the Muslim cultural community, rather than focusing on individual ethnicities, seemed the best approach for this project. As well, imams have direct access to the overall community and are considered to be the source of guidance and support, irrespective of their individual ethnicity.

Most Muslims living in Auckland either are refugees or have emigrated from countries in which the socioeconomic conditions left many people disadvantaged. Research indicates that refugees and migrants experience significant resettlement issues, including facing many barriers to accessing health services (Lawrence & Kearns, 2005). In general, most of the immigrants and refugees have no knowledge of mental health or even general health services in New Zealand (Lawrence & Kearns). At the same time, anecdotal evidence suggests that the services are rarely culturally responsive and they face nearly overwhelming difficulties in understanding the needs of Muslims, even if the communities have knowledge of the services available (Lawrence & Kearns).

Background and Aims of the Study

The Auckland District Health Board (ADHB) is presently adopting an evidence-based approach to the development or reconfiguration of funding and mental health planning. As part of this process, the board is utilising a project-based approach to planning and examining services across the spectrum or continuum of delivery.

Affinity Services, a community-based nongovernment organisation (NGO), was contracted by the ADHB to assess the level of knowledge of mental health within the wider Muslim community, increase mental health awareness, identify potential barriers to access, and determine how to improve access to mainstream mental health services. As part of this process, the project aimed to engage imams and assess their willingness to participate in delivering a psychoeducational message to raise awareness of the mental health needs in Muslim communities.

Review of the Literature

Initially, it seemed a complicated task to reach these communities and raise the issue of mental health. However, studies suggested that as leaders in the Muslim communities, imams could play an active role in raising mental health awareness (Abu-Ras, Gheith, & Cournos, 2008; Osman, Milstein, & Marzuk, 2005). Imams can serve as key links to accessing Muslim communities, since mosques are the common and most frequented meeting places for Muslims and the imams are esteemed as respected clerical leaders and elders in the communities. Muslims tend to approach them for advice on any number of issues, including those relating to mental health, such as family, social, and psychiatric problems, and they entrust the imams with personal and family information. Research has found that imams often serve as front-line mental health care providers and facilitators to help communities gain access to mainstream services, particularly in minority communities (Larson et al., 1988; Piedmont, 1968; Schindler, Berren, Hannah, Beigel, & Jose, 1987; Veroff, Kulka, & Douvan, 1981; Young, Ezra, Griffith, & Williams, 2003). An analysis of data in the United States by Wang, Berglund, and Kessler (2003) found that religious leaders continue to provide more mental health care than psychiatrists, including treatment of people with serious mental illnesses. Imams can therefore play a very important role in encouraging the community to understand and accept the importance of mental health awareness and in supporting those who suffer from mental illnesses.

Erickson and Al-Tamimi (2001) emphasised that community awareness about the availability of mental health services needs to be more widely promoted, which will help in allowing ethnic minorities to seek out access to services. It is therefore vital to have the imams of local mosques “on board” in terms of raising mental health awareness. The findings of the survey of imams done by Osman et al. (2005) in the United States strongly suggested a need for mental health professionals to support the imams in their vital role of improving access by members of the Muslim community to main-

stream mental health services. This viewpoint becomes even more important in the context of the Muslim communities in New Zealand. Through their survey, Osman et al. (2005) also discovered that most of the US-based imams had some form of mental health training or qualification.

Based on the findings from the above literature, it became obvious that the area of Muslim mental health was overdue for exploration in New Zealand. Since the Muslim communities in New Zealand are relatively new and small as compared to those in the United States and the United Kingdom, and many members are recent immigrants or refugees, the mental health issues faced by these communities are rather different, thereby necessitating a different approach. In addition, Muslims in New Zealand enjoy *relatively* more acceptance and less racial or religious discrimination in comparison with those in other countries. A study done by Shepard (2006) argued that while there have been incidents of racial or religious discrimination towards Muslims in New Zealand, by and large there is significant acceptance and support shown to Muslims by the general population. It might therefore be relatively easy to establish trust and build good relationships between the community and the mainstream mental health services. Indeed, Mohit (2001) argued that religious leaders, intellectuals, and women and men in positions of community authority should be made aware of the importance of mental health and involved in the formation of better systems of care.

Bate and Robert (2002) emphasised the importance of collaboration between the private sector and public health services, and this could contribute to the public sector's quality improvement initiatives. Similarly, there is a need for collaboration *with* the community to utilise members' knowledge in improving the quality of service delivery *to* that particular community. When mental health services work in collaboration with the imams, the mental health needs of the Muslim community are more likely to be identified and addressed, and in turn, the knowledge gained from such encounters can be used by mental health professionals to improve their knowledge of the community and hence improve the quality of service delivery.

Research Method

A qualitative approach was used in carrying out this study. The project team initiated the study by communicating with imams from the local mosques in Auckland. The first aim of our communication with the imams was to explain the purpose of our project and to assess their willingness to support us in raising mental health awareness. In the initial stages of communication, we became aware that, as a result of different cultural

beliefs and their lack of knowledge about local conceptualisations of mental health, the imams did not feel comfortable discussing this issue. Later, however, through processes of communication and building trust, the imams accepted the importance of mental health awareness, and they came to understand more about the persistent need for their involvement in mental health issues. Gaining the support of the imams was itself a successful first step.

From those mosques that provide regular services to the Muslim community, we invited imams to participate who were actively involved in the social services of the community as well as providing guidance as spiritual leaders. We omitted small centres where prayers are performed on an occasional basis and that do not have a regular imam. Participation was entirely voluntary and prospective participants were given information about the aims and purpose of the study, as well as some time to think about participating. They were also made aware that any outcomes of the research might be made available publicly.

All ten of the imams who were invited to take part in the study agreed to do so. Interview times were arranged with them and the method of the interview was explained. The interviews were conducted face-to-face using a semi-structured questionnaire. This provided the flexibility to alter the questions based on the information provided. When the interviews were completed, the hand-written data were typed and then returned to the participants to check for accuracy. The data were then analysed using thematic analysis.

Results and Discussion

The results from the interviews with the imams have been divided into six categories, based on the major themes identified through data analysis. The results clearly indicate the importance of Muslim mental health awareness and the value of community involvement in meeting those needs. The six major aspects of the results are now presented and discussed.

Level of Basic Mental Health and Services Knowledge by Imams

The imams interviewed were all immigrants, from a number of different countries; none were New Zealand-born. This is interesting when compared to studies conducted on the same topic in the United States and the United Kingdom by Sameera and Reddy (2007) and Hussain (2009), where Muslim communities have been present for centuries, which is not the case in New Zealand. Studies done by Osman et al. (2005) and Leavey (2008) showed that imams in those countries had varying levels of mental

health training and qualifications. More than half of the imams surveyed by Osman et al. (2005) had some kind of mental health or counselling qualification or training, whereas the findings of the current study demonstrate that only two out of the ten imams we interviewed had some form of qualification relating to mental health. Among the imams we interviewed, we could find only one additional imam who had some knowledge of mental health. Furthermore, only two of the imams we interviewed had some knowledge about Auckland-based mental health services.

These findings do not necessarily indicate that the imams knew little about mental health; it became evident that several of them were involved in mental-health-related work in the community. The difficulty in speaking with the imams was in identifying what the term "mental health" means in the New Zealand context.

Another interesting finding was that, initially, most of the imams appeared hesitant to talk about mental health in the Muslim communities. However, when they became aware that mental health is not limited to people with serious mental illnesses and that a variety of mental health issues are commonly present within the whole community, they became more comfortable talking about these issues in the community, as well as their own experiences of mental health in the Muslim communities.

Issues about which Community Members Usually Approach Imams

On the one hand, the imams stated that they did not have much knowledge of mental health, nor were they qualified in the subject. On the other hand, when asked about the kinds of issues for which they are usually approached by members of the Muslim communities, their answers indicated that they provide virtually direct mental health services to their communities without being aware of it. Following are the issues identified during the study for which imams were approached and which they deal with on a regular basis:

- Financial stresses
- Depressed mood
- Issues of settling in to a new culture and a new country
- Seeking advice and guidance
- Feelings of isolation, especially in the elderly
- Mental issues related to physical problems
- Post-traumatic problems
- Marital issues among migrants
- Teenage relationship issues with parents, including drug problems.

These include common issues faced by most people in society, but they can nevertheless have a huge impact on one's mental health. For immigrants and refugees, these challenges can be intensified by the stressors associated with immigration and trauma, thereby complicating their mental health distress and their needs in comparison with the general population. In the case of imams, people approach them not only for a second opinion, but, in fact, most people in Muslim communities share their secrets and issues only with the imams. This level of trust by community members, along with access to the information they share with the imams, places these clerical leaders in an important position for raising mental health awareness in their communities. These findings point toward an interesting idea, that if the imams have some basic mental health tools as well as the ability to identify issues relating to mental health, they can then use their position to encourage the person seeking advice to access help from specific mental health services if required. This will have a long-lasting impact on the mental wellbeing of the Muslim communities.

Barriers to Muslim Communities' Access to Mainstream Mental Health Services

Since the imams had little knowledge of the mental health system in New Zealand, their views of the barriers to accessing mental health services by the community may well reflect the limited knowledge and access that Muslim communities have to general health services overall. However, their views do highlight some important issues regarding access to mainstream mental health services. One of the main issues the imams raised in relation to barriers was their lack of awareness of the available health services. This is an important issue, especially for new immigrants, and most members of the Muslim communities living in Auckland are recent immigrants.

The lack of knowledge about Muslim culture by non-Muslim health professionals is also an important issue that runs parallel to the issue of a lack of knowledge about health services. If the health professionals, especially in primary health care, had a better understanding of the culture of their clients, it would be much easier to educate them about the available mental health services. This purposeful education is needed because most of the Muslim immigrants in New Zealand are from countries with underdeveloped socioeconomic cultures, and from societies that have been severely disrupted by armed conflict, and hence are without well-developed mental health systems, as exist in New Zealand. As well, most of the ethnicities within the Muslim communities are from developing countries and are closely linked to each other. As a result, an enormous sense of cultural stigma and discrimination associated with

mental illnesses exists (Lauber & Rōssler, 2007). Languages create another barrier that affects the ability of people within New Zealand's Muslim communities to freely express their views on their day-to-day life and their mental wellbeing. Lastly, a lack of finances for some members of the community is a barrier to accessing health services. This issue can also be linked to the lack of knowledge about health services, because some people do not know that most services are public health funded.

Suggestions for Overcoming Barriers to Accessing Mental Health Services

Suggestions by the imams for overcoming those barriers for Muslim community members in accessing mental health services emphasised two main issues. In their view, the Muslim communities need to be educated about mental health services, and similarly, health professionals need to be given some sort of cultural awareness education. Imams also indicated that the community leaders could play a vital role in educating their communities about health services in general, and mental health services in particular. Some imams also indicated that translating some of the service brochures into the languages commonly spoken by Muslims—for example, Arabic—would also have an impact on educating Muslims about mental health services.

The Role of Imams in Raising Mental Health Awareness in Muslim Communities

Imams have shown a keen interest in the project and have been very supportive throughout the process. When asked about their role in raising mental health awareness in the Muslim communities, their responses reflected the opinion that they were the key people in their communities. The majority of the imams indicated that they could play a key role in educating Muslim community members about mental health through speaking about it during the Friday *khutba* (sermon) and in other social gatherings. However, the majority of the imams also indicated that they needed to be trained in some form of basic mental health knowledge to be able to educate their communities.

Imams' Willingness to Participate in Mental Health Training/Workshops

Since the imams recognised that their knowledge of western concepts and approaches to mental health was very limited, and yet they were involved in the role of providing mental health support to the Muslim communities, they accepted their need to receive basic mental health training in order to better support and encourage those in their communities who were suffering from mental health issues. They saw that they could also raise mental health awareness by educating their communities. The majority of

the imams showed a keen interest in participating in mental health training or workshops in order to be better equipped. Only a few of the imams showed some reluctance to participate in the training, but that was due primarily to their time limitations and work commitments. However, no one gave a completely negative response.

Future Directions and Recommendations

In recent years, the implications of cultural and religious beliefs have been identified as one of the important foci of researchers in mental health tools for recovery. Our study opens ways for using culturally competent pathways to improve mental health service delivery to ethnic minorities living in New Zealand by those health service providers who have accepted that the one-model-fits-all pathway does not work in a multicultural society. The Muslim community has been perceived in a simplistic and generalised way by health professionals as being a difficult community to access. This study not only identifies the main access point for these communities by involving imams, but also identifies ways to work in collaboration with Muslim communities.

Imams could play a significant role not only in raising mental health awareness within Muslim communities but also by providing a useful resource for mental health professionals through giving advice regarding cultural and religious issues related to mental health. The project team now intends to support imams in gaining basic western mental health knowledge and training in order to equip them to deal with any mental-health-related issues they identify in the community or when approached by someone with problems. This will also help create communication channels with the imams, who will provide ongoing assistance to the health professionals in terms of gaining access to cultural support when needed. Additionally, it will help community members gain increased access to mainstream mental health services.

Conclusion

Undertaking this study has opened new avenues for further research initiatives exploring the role of the wider community itself in the utilisation of culturally competent pathways for mental health service delivery. This not only applies to Muslim communities but also suggests a direction for exploring the possibilities of the role and importance of religious leaders from other communities in raising mental health awareness and increasing access to mainstream mental health services. The research findings have confirmed the hypothesis that imams can play a significant role in

supporting their community members with accessing help for mental health issues, and that a strong need exists for training imams in basic mental health knowledge as well as for training health professionals in cultural awareness. However, deeper and more extensive research is still needed into the viewpoints of Muslim clients of mental health services and their families.

References

Abu-Ras, W., Gheith, A., & Cournos, F. (2008). Religion and imams role in mental health promotion: A study at 22 mosques in New York City's Muslim community. *Journal of Muslim Mental Health, 3,* 157–178.

Bate, S. P., & Robert, G. (2002). Knowledge management and communities of practice in the private sector: Lessons for modernizing the National Health Service in England and Wales. *Public Administration, 80*(4), 643–663.

Erickson, C. D., & Al-Tamimi, N. R. (2001). Providing mental health services to Arab Americans: Recommendations and considerations. *Cultural Diversity and Ethnic Minority Psychology, 4*(7), 308–327.

Hussain, F. (2009). The mental health of Muslims in Britain: Relevant therapeutic concepts. *International Journal of Mental Health, 38*(2), 21–36. doi: 10.2753/IMH0020-7411380202

Larson, D. B., Hohmann, A. A., Kessler, L. G, Meador, K. G., Boyd, J. H., & McSherry, E. (1988). The couch and the cloth: The need for linkage. *Hospital and Community Psychiatry, 39,* 1064–1069.

Lauber, C., & Rōssler, W. (2007). Stigma towards people with mental illness in developing countries in Asia. *International Review of Psychiatry*, *19*, 158–178.

Lawrence, J., & Kearns, R. (2005). Exploring the "fit" between people and providers: Refugee health needs and health care services in Mt Roskill, Auckland, New Zealand. *Health and Social Care in the Community, 13*(5), 451–461.

Leavey, G. (2008). UK clergy and people in mental distress: Community and patterns of pastoral care. *Transcultural Psychiatry 45*(1), 79–104.

Mohit, A. (2001, January). Psychiatry and mental health for developing countries: Challenges for the 21st century. Paper given at the 13th Congress of the Pakistan Psychiatric Society, Islamabad, Pakistan. Retrieved February 2, 2011, from http://www.emro.who.int/mnh/whd/TechPres-Pakistan.pdf

Osman, M. A., Milstein, G., & Marzuk, P. M. (2005). The imam's role in meeting the counseling needs of Muslim communities in the United States. *Psychiatric Services, 56,* 202–205.

Padela, A., Killawi, A., Heisler, M., Demonner, S., & Fetters, M. D. (2010, November 19). The role of imams in American Muslim health: Perspectives of Muslim community leaders in southeast Michigan. *Journal of Religious Health.* Advance online publication.

Piedmont, E. B. (1968). Referrals and reciprocity: Psychiatrists, general practitioners, and clergymen. *Journal of Health and Social Behavior, 9,* 29–41.

Refugee Resettlement New Zealand. (2005). *Refugee Resettlement's Work.* Retrieved April 25, 2011, from http://www.refugeeservices.org.nz/faqs/refugees_in_nz

Sameera, A., & Reddy, L. A. (2007). Understanding the mental health needs of American Muslims: Recommendations and considerations for practice. *Journal of Multicultural Counseling and Development, 35*(4), 207–216.

Schindler, F., Berren, M. R., Hannah, M. T., Beigel, A., & Jose, M. (1987). How the public perceives psychiatrists, psychologists, non-psychiatric physicians, and members of the clergy. *Professional Psychology: Research and Practice, 18*(4), 371–376.

Shepard, W. (2006). New Zealand Muslims and their organizations. *New Zealand Journal of Asian Studies, 8*(2), 8–44.

Veroff, J., Kulka, R., & Douvan, E. (1981). *Mental health in America: Patterns of help-seeking from 1957–1976.* New York: Basic Books.

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research, 38*(2), 647–673. doi: 10.1111/1475-6773.00138

Young, J. L., Ezra, E. H., Griffith, M. D., & Williams, D. R. (2003). The integral role of pastoral counseling by African-American clergy in community mental health. *Psychiatric Services, 54,* 688–692.