Can mental healthcare for Muslim patients be person-centred without consideration of religious identity? A Concurrent Analysis

Abstract

Background: Muslims constitute the largest, fastest growing religious minority in the UK. Globally, nurses are legally, morally and ethically obliged to provide non-discriminatory, person-centred, culturally sensitive care. This obligation includes supporting people with their religious needs where appropriate, but there is evidence this is not always happening, particularly for Muslims in mental health care.

Aims: This paper reviewed primary research to address the question: Can mental healthcare for Muslims be person-centred without consideration of religious identity?

Methods: Narrative synthesis and concurrent analysis. Searches were conducted post 2000 in MEDLINE, CINAHL, SAGE, PsychINFO and ASA with terms: 'Muslim', 'Islam*', 'mental health', 'nurs*', 'person-cent*', 'religio*'. Narrative data was analysed for commonalities and themes.

Findings: Seven studies of sufficient quality were analysed. Unconscious religious bias was the overarching theme linking the findings that healthcare staff felt ill-prepared and lacked necessary knowledge and experience to work with diverse patient groups. Unconscious racial bias contributed to limited cultural/ religious competence in treatment and care.

Conclusion: Religious identity is core for Muslim patients, so this group may not be receiving the person-centred care they deserve. Nurses need cultural and religious competence to deliver person-centred, holistic care to diverse patient populations, yet the importance of religious practice can be overlooked by staff, with harmful consequences for patient's mental and spiritual welfare. This paper introduces a welcome pack that could help staff support the religious observance of those Muslim patients/service-users wishing to practice their faith during their stay in health services.

Key Words:

Muslim, Mental Health, Nurse, Unconscious Bias, Religion, Race, BAME, Spirituality, Person Centred Care.

Background

Muslims constitute the largest, fastest growing minority religious group in Scotland and the UK (Elshayyal, 2016; National Records of Scotland, 2014; Hussain, 2009). Correspondingly, nurses will encounter Muslim patients with increasing frequency. Healthcare providers have legal, ethical, and moral obligations to respect the background and rights of patients, families, and carers concerning care decisions (Equality Act (2010); Mental Health (Care and Treatment) (Scotland) Act (2013); Nursing and Midwifery Council (NMC), 2015; Patient Rights (Scotland) Act (2011). In the UK and beyond, lack of religious awareness amongst staff regarding the needs of Muslim patients may undermine the meeting of these obligations (Hussain, 2009; Rondelez, 2018).

For the purposes of this paper the term 'nurse cultural and religious competence' implies the proactive seeking of knowledge regarding the cultural and religious factors influencing the health beliefs and behaviours of the Muslim patient and the enacting of this knowledge in order that barriers to care are overcome and needs more adequately met (Betancourt et al., 2003; Western Governors University, 2021).

Lack of religious awareness can be particularly problematic in mental health nursing. Patients enduring psychotic episodes often present with delusional beliefs containing a religious element (McKay & Ross, 2021), and nurses can struggle to distinguish between helpful religious beliefs and distressing delusions (Kang & Moran, 2020; Ouwenhand, 2020). Further, Mitha (2018) observed that Muslims often delay seeking medical help until mental health conditions become more acute. His study highlighted the disproportionate negative impact of social determinants of health on Scottish Muslims, including discrimination and Islamophobia. This underlines the need for mental health nurses to understand the centrality of religion for Muslim patients and their families.

From its inception in the 1940's, equity, universality, and equality have been foundational National Health Service (HNS) principles, promising equal medical advice, care and treatment to those in need, regardless of background (Central Office for the Ministry of Health, 1944, as cited in Department of Health, 2003). In 2002, the Scottish Government produced *Fair for All: Working Towards Culturally Competent Services* (Scottish Executive, 2002). This stated that

any service claiming cultural competence must recognise diverse backgrounds, providing appropriately for religious and cultural needs, including diet, hygiene, and worship.

Person centred care is a contemporary expression of equity in NHS policy (Brennan, 2019; Scottish Government, 2019), essentially requiring all needs to be recognised and respected, including faith and belief. For example, The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, requires that services take account of religious and cultural needs in order to provide person centred care (Department of Health and Social Care, 2014). Nursing remains central to articulating this NHS vision of equality of access (Braithwaite, 2018; Moore et al., 2021). However, disparities persist regarding access and outcomes for minority groups, including Muslim patients wishing to practice their religion in healthcare settings (Chree, 2020; Harris, 2018; Laird et al., 2007; NHS Scotland, 2009; REACH, 2008). For example, Martin (2015) found 54% Muslim patients reported being excluded or ignored by staff, 43.9% experienced problems related to wearing Islamic dress, 36.6% reported offensive or insensitive verbal remarks, 25.6% faced problems related to Islamic holidays, 18.9% prayer rituals, and 3.7% reported physical assault. Lack of healthcare practitioner knowledge and stereotyping were seen as additional forms of discrimination encountered (Martin, 2015, p. 50).

This paper examines cultural and psychological explanations for these disparities. From a local cultural perspective the importance of religion has diminished. Scotland has become more secular, with 37% of the population recorded as having no religion (Scotland's Census, 2021). One example of adapting health services to this change is seen in its spiritual care workforce. NHS Scotland chaplaincy service does not require faith in any religion as a prerequisite for the role (Mowat & Swinton, 2007; Scottish Government & NHS Scotland, 2009). Religion is seen as one aspect of an individual's spirituality, facilitated on an 'as required' basis, but it is *spiritual* care that is seen as the primary product of modern chaplaincy in Scotland. One unintended consequence of this inclusive strategy is increased likelihood of minority religious beliefs and practices being misunderstood and excluded as religion becomes less valued by the local culture.

The majority of UK Muslims come from minority ethnic backgrounds (Iqbal, 2016; Office for National Statistics, 2019). Any psychological explanation for exclusion must therefore include Unconscious Racial Bias (URB); the tacit favouring of one racial group over another. In

healthcare this bias can lead to adverse consequences for patient care. These are further explored in the Discussion section of this paper. URB occurs at an unconscious, unintentional level, operating spontaneously and influencing nurse behaviour, perceptions, and memory of events (FitzGerald & Hurst, 2017).

The lack of targeted research related to Muslim specific experiences of mental healthcare has been recognised previously (Hussain, 2009; Laird et al., 2007; Padela et al., 2012). Bonino (2017) describes Scotland's Muslims as invisible to academics studying Muslims in the Western world. A literature review was therefore undertaken to answer the question: Can mental healthcare for Muslim patients be person-centred without consideration of religious identity? Given demographic trends and increasing numbers of Muslims in Western countries the findings have relevance beyond Scotland (Office for National Statistics, 2019).

Methods

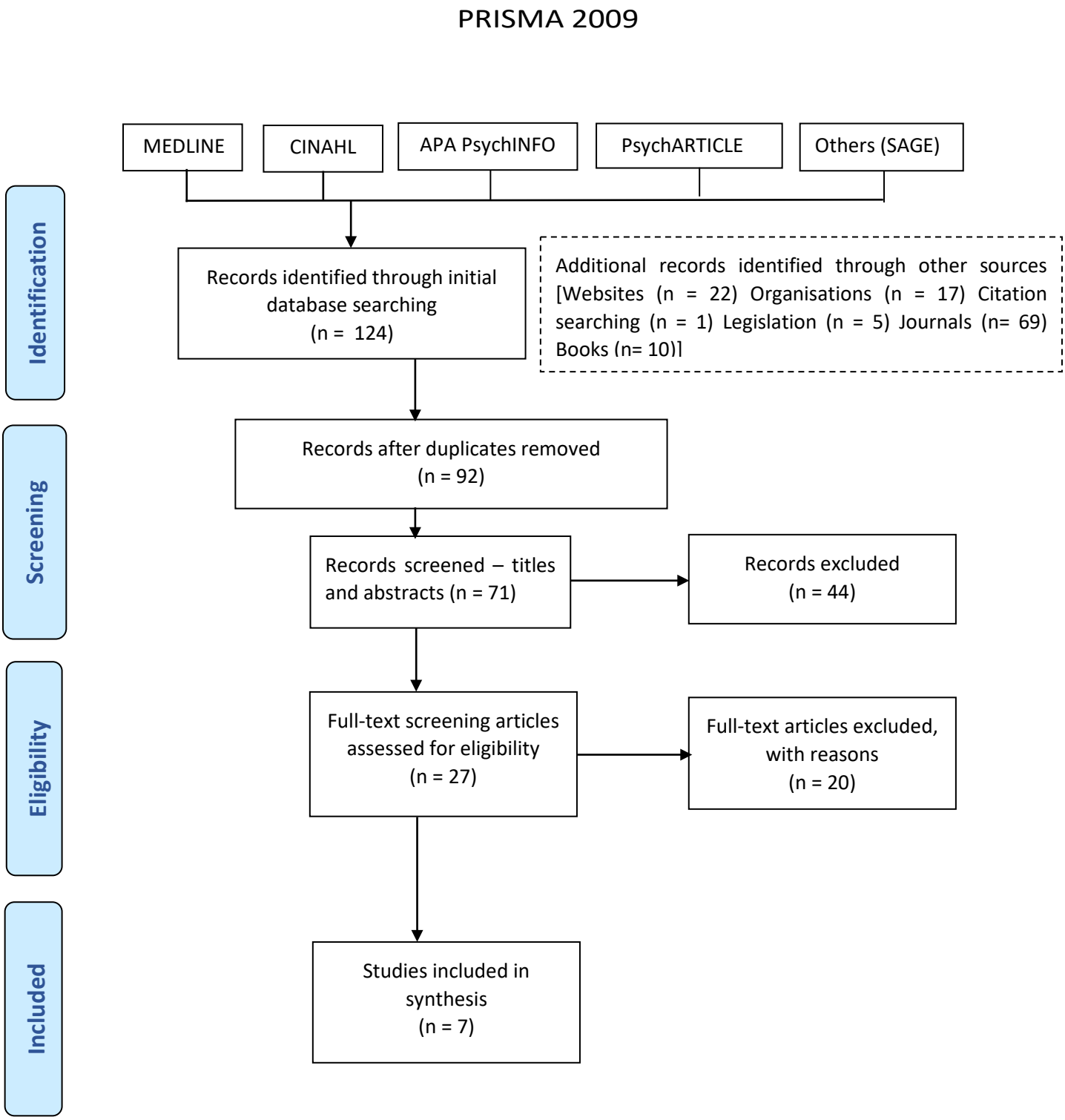
Concurrent Analysis

Concurrent Analysis is a form of meta-synthesis (Kelly & Snowden, 2020; Snowden & Martin, 2010). It analyses narrative data from peer reviewed research of any method where the data is of sufficient quality and relevant to the research question (Snowden & Young, 2017). The following databases were searched for primary research examining the place of religion in mental health settings using a range of key terms (religion*, mental health, worship, Islam, Christian*, Muslim) and booleans: MEDLINE, Cumulative Index to Nursing, and Allied Health Literature (CINAHL), SAGE Journals Online, American Psychological Association (ASA) PsychINFO, and PsychARTICLE.

The search revealed considerable empirical research employing a wide range of methods including questionnaires, individual, and group-based interviews, observations, and patient stories. The final search elicited 71 results necessitating a study selection screening approach, initially of titles and abstracts, resulting in the elimination of 44 studies (Coughlin & Cronin, 2021). The remaining 27 papers underwent full text screening, leaving seven papers demonstrating the requisite quality and pertinent data (Burgess et al., 2006; Coughlin & Cronin, 2021). See PRISMA diagram (figure 1). Whilst the focus of this paper is on the Scottish/UK context the issues addressed have global relevance. This has been reflected in the research selected. The Critical Appraisal Skills Program (CASP) was used to assess study

quality as its specialised checklists are relevant to a wide range of research designs (Aveyard, 2021; CASP-UK, 2020; Long et al., 2020).

Figure 1. PRISMA Flow Diagram



Qualitative approaches dominated the final selection. Methods included phenomenology, ethnography, and grounded theory papers (table 1). Primary data and first-hand descriptions from these papers were coded line by line and categorised thematically using the constant comparison method. Sense checking was achieved through independent researchers coding the same sections of narrative and comparing interpretations. Where disagreement emerged, consensus was achieved through discussion and reflection with colleagues (McGhee, Marland, & Atkinson, 2007).

Insert *Table 1 here*

Findings

Four key themes emerged as barriers to person-centred care (figure 2), the first pertaining to the patient, and the other three to staff. The overarching theme, overlapping with but distinct from Unconscious Racial Bias, was Unconscious *Religious* Bias. The four themes were:

1. The relationship between recovery and prayer, ritual and worship,
2. Incomplete recording of patient information,
3. Staff misunderstanding, lack of knowledge, and anxiety,
4. Unconscious racial bias.

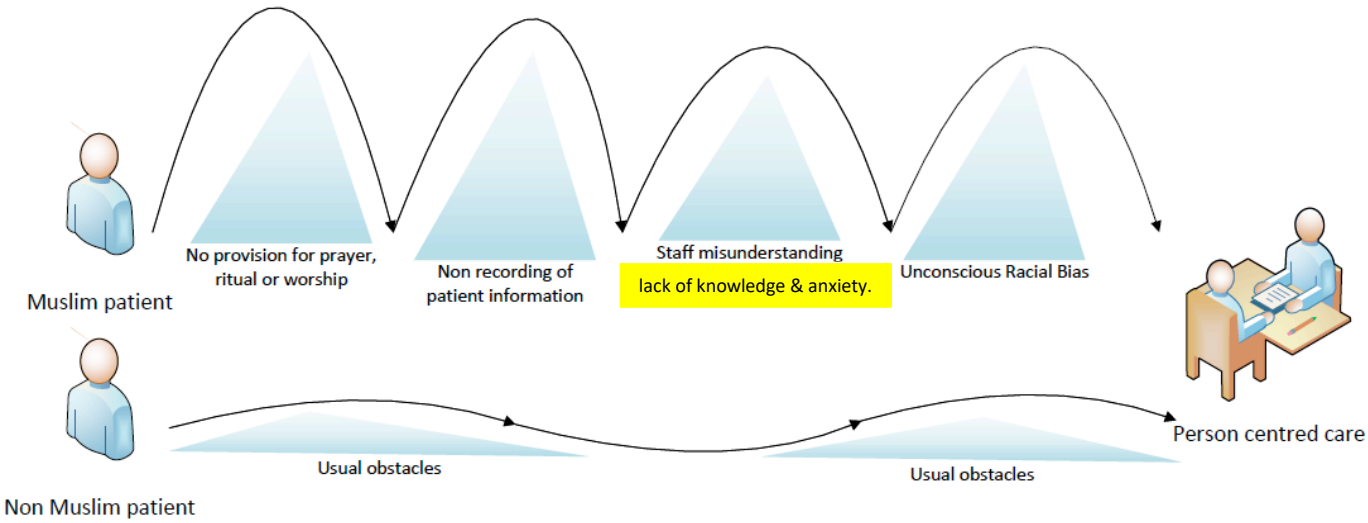


Figure 2. Graphic representation of key themes presented as barriers to person centred care for the Muslim patient.

1. **The importance of prayer, ritual and worship and the impact of religious practice on treatment, care and recovery**

Martin (2015) states that healthcare practitioners can only hope to realise the true impact and clinical significance of religion on the health and wellbeing of their Muslim patients by studying Islam as their way of life rather than as a religion as largely understood in Western society. In their quantitative study, Maltby et al. (2008) found a positive relationship between religious prayer and wellbeing. These relationships were further expanded on in the qualitative studies. For example, a patient explained: "*I think faith plays a massive part in recovery*" in Heffernan et al. (2016, p. 349). One participant described the "*peace and calming nature of prayer*," as being therapeutic in itself, whilst another saw prayer as a means to an end, part of a process of engagement with more 'conventional' services: "[Prayer] *helped to motivate her to work with a psychotherapist*" (Raffay et al., 2016, p. 8).

Conversely, absence of facilities and fear of persecution prevented patients praying:

> "*…once you're in hospital it's all restricted isn't it…and you can't go to no mosque or no church* [so] *I'll pray in my room and some guy walked in…'this guy's mad, what's he doing, praying to a wall', so, I didn't want to bring my religion into that place*" (Heffernan et al., 2016, p. 350).

Some patients felt there should be a clear separation between religion and mental health services (Heffernan et al., 2016).

2. **Issues relating to the recording of patient information**

Inconsistencies were found in the recording of patient religious affiliations on admission (Hussain, 2009; Kang & Moran, 2020; Walsh et al., 2013). Evidence suggests mental health nurses do not always enquire as to the level of importance religious observance plays in the patient's life, and how best to accommodate such needs whilst under their care (Heffernan et al, 2016; Kang & Moran, 2020; Walsh et al., 2013). A Christian patient expressed how crucial this was:

> *"when new patients arrive in hospital someone from the spiritual care should go and see them straight away, to make them aware that there is a church service going on every week"* (Raffay et al., 2016, p. 7).

Often, information gathered on admission was not revisited or monitored and some staff placed the onus on patients to disclose religious needs. Fear of offending or not being politically-correct potentially exacerbated the situation:

> *"…sometimes people find asking the question quite unsettling…it's like a taboo subject…the patient has to tell us what their religion is. We won't necessarily be the ones that ask that so maybe it can be [missed] sometimes"* (Kang & Moran, 2020, pp. 12, 13).

Fear of negative reactions from healthcare practitioners may have led to patients withholding information concerning religious affiliations:

> *"I find it difficult when people put me down for my faith…you don't want people laughing in front of us while we're praying and that"* (Raffay et al., 2016, p. 6).

3. Staff misunderstanding, lack of knowledge, and anxiety

Meeting the religious needs of patients from diverse backgrounds generated anxiety in many healthcare staff (Hart & Mareno, 2013; Kang & Moran, 2020; Markey et al., 2018). Staff feared offending patients whose background they knew very little about, demonstrated in the comments from one nursing student:

> *"I still would be very anxious because do you know if you approach them in any way…like even though you wouldn't mean to like…they might think that…they mightn't know that you didn't mean to em…offend them. You would have a real fear of doing something wrong"* (Markey et al., 2018, p. 262).

Often childhood conditioning engendered negative views and poor understanding of other cultural and religious groups (Markey et al., 2018). This represented a potential barrier to the delivery of culturally and religiously competent care:

> *"…hearing things from your parents about Blacks…you know, they would have negative attitudes and beliefs towards them and you can't help but learn them too."* (Markey et al., 2018, p. 264).

Distinguishing delusional behaviours from religiosity proved challenging for staff, often leading to misinterpretation:

> *"things…they were saying…they were quite psychotic, but nobody was actually picking up…that this was actually in relation to their religion…[it] made sense when [it was]…explained…by the family"* (Kang & Moran, 2020, p. 17).

Most of the research reflected the experience of religious Christian patients. Significant gaps were identified in nurse knowledge (Kang & Moran, 2020) and education curricula regarding wider perspectives, with one nurse stating:

> "*Any education I have had regarding cultural diversity has been shallow*" (Hart & Mareno, 2013, p. 2227).

A lack of understanding can stand in the way of professionals across healthcare services recognising the important inter-play between religious context, healthcare seeking behaviours, and overall experience. Healthcare staff looking after Muslim women utilising a UK based NHS maternity care unit identify what might be a way forward.

> *"Culture and religion is a big thing, and people do not really seem to understand that there is a culture and there is a religion, and they are not the same. I think that is something that needs to be identified; training should help highlight the difference between culture and religion."*
>
> *"I think they need to look at training and maybe revamp it and make it more in-depth and address it to what we deal with on a daily basis, rather than a Human Rights Act and ten questions online about general equality and diversity"* (Hasan et al., 2020, p. 7).

4. Unconscious Racial Bias

In a US based study, Martin (2015) draws attention to the sharp rise in societal discrimination and anti-religious sentiment directed towards Muslims since the tragic September 11, 2001 attacks. The study explores the spill-over of this type of discrimination within healthcare settings and gives voice to the experiences of Muslim patients:

> *"Because of my hijab I feel I am ignored."*
>
> *"…the fact that our holy day is Friday was never taken into consideration even after being explained."*

"They choose to come right at prayer to give medicine or care. If you don't break prayer they don't come back till the next hour or two"

"*Was served pork for breakfast after overnight hospital stay. Apparent oversight*."

"…awkward looks in terms of the prayer rituals" (Martin, 2015, pp. 50, 51).

In an Irish study, some nursing students expressed clearly stereotypical and ethnocentric views, often going unchallenged in both training and practice:

*"We haven't seen much of it (different cultures), as Ireland has only recently become a multicultural Ireland, so really hand on heart we can say we just haven't had much exposure to them and their beliefs" (*Markey et al., 2018, p. 263).

*"[H]ow do we deal with these people? They are not Irish…they are different from us" (*Markey et al., 2018, p.265).

Hart & Mareno (2013) found most participants saw it as the responsibility of the minority culture to 'fit in', and not the other way around. The same study found bias against certain communities, cultures, and community groups (Hart & Mareno, 2013). One nurse expressed an alternative view:

"The biggest challenge in integrating culturally competent health care in my clinical practice comes from other colleagues in my own profession and those other medical professions not having the knowledge, understanding or respect of other culture beliefs, issues" (Hart & Mareno, 2013, p. 2227).

This more critical comment suggests cultural competence can be attained by improving knowledge, which in turn suggests a key role for education. This will be returned to.

DISCUSSION

Authentically individual, holistic care is attained through an understanding of culture, tradition, belief-systems, and demonstrations of cultural competence (Oman, 2018; Rassool, 2014). This movement beyond the conventional medical model to a holistic one has been advocated by the World Health Organisation (WHO) for over two decades (WHO, 1998). For many Muslims, religious values are central to health, with biopsychosocial needs often

secondary to spiritual concerns (Lovering, 2014, as cited in Rassool, 2014). For the Muslim, religion touches every aspect of life including, diet, hygiene, dress, and, the way relationships are conducted (Bradley, 2017). Prayer and worship (ibaadah) forms the means to connect with God, forging a deep enduring relationship (Henry, 2015). Rasool (2015) argues that even 'non-observant' Muslims seek spiritual and religious interventions when facing health-based adversity. For the Muslim then, religion is often the key marker of identity (Mitha, 2018). However, despite the growing recognition that health is holistic, operationalising this ideal remains difficult, particularly regarding spirituality and religion (Winiger & Peng-Keller, 2021). The four themes emerging from this study may therefore help by framing practical solutions, so their connection to the wider literature is discussed first.

The importance of religious activity

There is a long history of religious practice being overlooked by staff, with negative consequences for patient's mental and physical welfare (Barker, 2001; Baker and Rose, 2021; Cornah, 2006; Doufesh et al., 2014; Whitley, 2019; Olver, 2013). However, it should be noted that not all experience of religious observance is positive. Religious obligations imposed on individuals through family, community pressure or through guilt may hinder recovery (Heffernan et al., 2016). Further, Loewenthal (2001) and Mohr et al. (2006) described the potentially negative impact religious beliefs can have for some patients. For example, people experiencing psychosis express delusional beliefs, and these beliefs often have a religious element (Pastwa-Wojciechowska, Grzegorzewska, & Wojciechowska, 2021). In some of these instances religious beliefs can do more harm than good (Mohr & Huguelet, 2004). Possibly as a consequence of this, the importance of religion is often underestimated or considered harmful by staff (Sofou, Giannakopoulos, Arampatzi, & Konstantakopoulos, 2021). Sofou et al., (2021) concluded that a better understanding of the research into the place of religion and spirituality for individuals would be helpful.

Heffernan et al.'s (2016) study examined the mechanisms through which religion influenced the recovery of patients with psychosis. Patients explained the value of religious expression in optimising their mental and physical wellbeing. Religious beliefs provided structure, operating as guidelines, helping to manage adverse experiences, moderate unhelpful behaviours such as 'bad' language, drug use and instead encouraged them to think of

others. This in turn lifted mood and spirits, enhancing recovery (Heffernan et al., 2016). Importantly, four of the ten patient participants were Muslim, and they disclosed fears of social disapproval from staff and other patients whilst hospitalised, severely restricting their religious expression, triggering feelings of guilt and loss, and impeding recovery.

Lack of facilities, fear of misunderstanding, and persecution often prevented patients praying. It was recognised that the principal researcher; a white British non-religious mental health professional, may have influenced the types of disclosures made (Heffernan et al., 2016). Patients may have held back on disclosing experiences due to mistrust based on perceived lack of understanding on the part of the professional or of negative prior experience. This reticence threatens to mask the true extent of the issues faced and corresponding needs (MIND, 2020). There is increasing evidence that service-users seek alternatives to the medical model when it fails to meet holistic needs, alternatives which consider worship/prayer as a form of therapeutic treatment (Chen & VanderWeele, 2018: Hart & Mareno, 2013; Heffernan, 2016; Markey et al., 2018; Raffay et al., 2016).

Staff misunderstanding, lack of knowledge, and anxiety

Meeting the religious needs of patients from diverse backgrounds created anxiety in many healthcare staff, whose perception was that their lack of knowledge, cultural and religious awareness, limited resources, and institutional culture stood in the way of delivering equitable, patient-centred care (Hart & Mareno, 2013; Kang & Moran, 2020; Markey et al., 2018). These results are consistent with the wider literature, showing that nurses and nursing students were uncomfortable around unfamiliar forms of religious activity (Attard et al., 2019; Bassett et al., 2015; Festini et al., 2009; McSherry et al., 2020).

This is particularly salient in mental health settings. Ouwehand et al. (2020) point out the challenges of differentiating delusions from unfamiliar religious practices, representing a potential barrier to the delivery of religiously competent care. The testimony of Raf Hamaizia (2021), a young British Muslim man, highlighted how a lack of knowledge and awareness can lead to behaviour considered normal for millions of people worldwide being profoundly misinterpreted. During his stay on a psychiatric ward, one nurse became alarmed upon observing him praying in his room. The nurse associated the behaviour with symptoms of psychosis and proceeded to offer medication, recording that Hamaizia had been seen

speaking to himself in his patient notes. Hamaizia (2021) described his stay as distressing. His time on the ward heightened his consciousness of being a minority in a predominantly white, non-religious setting. He felt compelled to adapt his behaviour to suit the majority culture, fearing he might otherwise be detained for longer. There are parallels here with the infamous study '*On being sane in Insane Places*' (Rosenhan, 1973) where study participants pretended to experience psychotic symptoms to get admitted to psychiatric hospitals. Their subsequent behaviour was consistently interpreted through this lens.

The outcome of this disconnection for Hamaizia (2021) was that he lost trust in staff whom he came to see instead as encroaching on his basic rights and freedoms. He also concluded that staff need greater cultural awareness including more empathy and sensitivity to the needs of patients from different cultural backgrounds, many of whom are vulnerable members of marginalised communities. This echoes the experience of a group of Muslim women participating in a Glasgow-based community-health project who stated a key barrier to accessing vital mental health services was staff misunderstanding of their religious beliefs and values. Religion was a source of hope for them. Practice of daily prayers was likened to self-administered therapy, alleviating feelings of depression and suicidal ideation (REACH, 2008). Whilst a small study, the findings of positive function of religion combined with fear of being misunderstood by being viewed through the Western lens were consistent with the wider literature and provide a window into the kinds of challenges to be expected as the Muslim population in Scotland grows (Elshayyal, 2016; National Records of Scotland, 2014).

Incomplete recording of patient information

Islamic religious observance requires specific practices, including five daily prayers and ritual ablutions (Winter & Williams, 2002). Whilst patients' religious affiliation is usually recorded on admission, further enquiries regarding the priority of religious observance and how this can be supported, offers to improve outcomes and decision making (Department of Health, 2006; Heffernan et al., 2016; Koenig, 2004). Walsh et al. (2013) discovered inconsistencies in patient demographic data held by several mental health trusts. Information gathered through questionnaires involving 71 mental health patients was compared to information held on systems and patient care plans. In 57 cases, religious/practicing patients were recorded as non-religious/practicing and vice-versa. Whilst patients communicated specific

details concerning their religious practices, these were not noted, impacting information integrated into care plans and the type of religious and spiritual support given.

Before 2010, enhanced care plans included a prompt to take account of cultural/religious needs. Walsh et al. (2013) suggest the absence of this reminder may have contributed to staff failures to engage in discussions around religion and culture, undervaluing its significance for patients and failing to incorporate this key information in care plans. Furthermore, staff acknowledge prioritising risk management over accommodating the religious and cultural needs of their patients (Kang & Moran, 2020). This falls short of UK Department for Health plans to include patients in their care and treatment, for care-packages to be self-directed and personalised, considering service-users spiritual and religious affiliation (Department of Health, 2006; 2007, 2009; Department for Health and Social Care, 2018).

Unconscious Racial Bias

Issues of race, culture, and religion are often at the forefront of political and academic debate (Al Jazeera, 2021; Government UK, 2021; Hutcheon, 2020; Razai et al., 2021). The thread uniting all the themes emerging from this study is the presence of Unconscious Religious Bias, manifested in the tacit othering of Muslim patients. Anscombe (2010), Eaton (2000), Murad (2020) and, Schiffer & Wagner (2009) have viewed this phenomenon in an historical context. The 7th and 8th centuries saw the spread of Islamic influence as far west as central France. The subsequent Crusades and the rise of the Ottoman empire led to a Europe identifying itself in opposition to Islam, with Muslims characterised as an enemy at the gates; ''*Turks at the gates of Vienna*" (Schiffer & Wagner, 2009, p. 81). Echoes of this perception of Muslims as alien to Europe persist in more recent events such as the 'ethnic cleansing' of Muslims during the 1995 Bosnian war (Bećirević, 2014). It is reflected in contemporary minaret bans in Switzerland and restrictions on hijab (head-covering) in France (Murad, 2020; Traynor, 2009). In a recent Chatham House survey involving ten European countries, 55% would like to see an end to Muslim immigration (Dettmer, 2017).

Elshayyal (2016) observes that in 2011, 90.45% of Scottish Muslims were from Asian, Black or Arab backgrounds. In the period 2001-2011 Scotland's diversity rose by 29%, the Muslim population representing a rapidly increasing demographic at 76,737, equating to 1.4% of the

overall population (National Records of Scotland, 2014). Census data for England also shows a growing Muslim population, from 4.7% in 2001 to 5.6% in 2016 (Office for National Statistics, 2012), yet disparities persist within healthcare between BAME and white patient populations at ward, diagnostic, and organisational level (Bradby, 2010; Department of Health, 2008; Lacobucci, 2021; NHS, 2004; Scottish Executive, 2002).

Unconscious Racial Bias is important because it represents a barrier to understanding diverse patient populations (Department of Health and Social Care, 2018; Marcelin et al., 2019; Narayan, 2019). Potential consequences for the mental and physical welfare of patients include unnecessary use of coercive measures, misjudging the need for pro re nata (PRN) medication and, as seen by Rosenthal (1973) and Hamaizia (2021), documenting misinterpreted symptoms/behaviours in patient records (Baker and Rose, 2021; Department of Health and Social Care, 2018).

While some NHS trusts and other government bodies have introduced Unconscious Bias (UB) training, its efficacy has been called into question (Ashworth-Hayes, 2021; Elsom, 2021; Feilder, 2020; NHS Blackpool Teaching Hospitals NHS Foundation Trust, 2021). The government's recent Commission on Race and Ethnic Disparities Report, claims institutional and systemic racism does not exist in the UK, a position met with profound scepticism from some healthcare leaders who argue that this is not reflective of their experience (Government UK, 2021; Lacobucci, 2021). The problem of institutional racism is profoundly difficult to address, especially if much of it is unconscious. Tate & Page (2018) are more sceptical still, seeing the URB agenda itself as a method of maintaining institutional racism and excusing 'whiteliness'.

A solution

Solving institutional problems with deeply political roots in eighth century 'othering' is beyond the scope of this paper. Suggesting practical solutions which progressive organisations may adopt to improve person centred care is not, however. Critical awareness of social inequalities and systemic racism is necessary for all nurses to recognise and confront their own thinking if they are to provide equitable care (Bucknor-Ferron et al., 2016). Most nurses see themselves as care givers; representatives of the profession's values and ethical code, offering fair and equal treatment to all (Barbee, 1993; Nursing and Midwifery Council

(NMC), 2015; Scottish Executive & NHS Scotland, 2006). There will inevitably and regrettably, be a small number of nurses who hold racist views (Coghill & Swift, 2020), but such attitudes can be challenged using existing codes of practice and anti-racist legislation (Equality Act (2010); Mental Health Act (1983); Mental Health (Care and Treatment) (Scotland) Act (2015) and the Patient Rights (Scotland) Act (2011).

By definition the problem of unconscious bias is more subtle (Watson & Malcolm, 2021). Nevertheless, those willing to confront their own unconscious biases have the potential to drive positive change in healthcare provision, improving institutional culture, and access to person-centred care for all. If unconscious bias, both religious and racial, is identified and brought into the light, any subsequent continuation of the same practice by individuals is rendered conscious and volitional (Gillborn et al., 2021; Tate & Page, 2018; Woolway, 2021). Surely few who have chosen to enter a caring profession which claims to be grounded in equity would choose to continue with culturally incompetent practice (Central Office for the Ministry of Health, 1944, as cited in Department of Health, 2003).

On a practical level, a Welcome Pack such as that presented in Fig. 3, provides an example of how cultural and religious awareness amongst staff can be raised while offering a practical resource to support the religious observance of those Muslim patients/service-users wishing to practice their faith during their stay in mental health services. This Welcome Pack or any intervention needs to be evaluated, but it is clear that practicing religious patients would welcome greater support from mental health care providers in continuing their practice whilst under their care (Heffernan et al., 2016; Degrie et al., 2017; Mohr et al., 2006). Mental health service users believe it could lead to more therapeutic relationships with staff, and recovery has been perceived as more achievable when mental health services were culturally sensitive, made modifications to the environment, integrated religion into psychotherapeutic interventions, and worked closely with religious leaders, especially to prevent conflicting advice (Heffernan et al., 2016). Increasingly, mental health professionals and academics within the Muslim community recognize this need, developing specifically Muslim perspectives on psychotherapy (Carle, 2019; Rothman & Coyle, 2018; Sabry and Vohra, 2013).

The relationship between religious and delusional beliefs is complex (McKay & Ross, 2021). Over twenty years ago Bowman (1998) endorsed the need for mental health professionals to be educated about a wide range of religious beliefs, so that they are better able to

differentiate between unhelpful behaviours and religious observance. This needs to be operationalised, so that no one else will suffer Hamaizia's (2021) experience of prayer being misinterpreted as psychosis. More generally, a welcoming environment of understanding grounded in deeper knowledge of the importance of religion for Muslims in particular, is likely to facilitate rather than prevent recovery for all (Department of Health, 2009; Erickson, & Al-Timimi, 2001; Sabry & Vohra, 2013). Given that the Welcome Pack may be used in psychiatric wards/units, the safety of its contents should be fully risk assessed on a case by case basis.

The 'Welcome Pack' contains items necessary to perform daily prayers and sits alongside a training video or briefing meeting to raise awareness amongst staff of the basic religious requirements of Muslim patients. Total estimated cost: £25.73 (eBay Inc, 2021).

Storage bag to contain six prayer items.

Qur'an

Prayer mat

Compass

Tasbih, Prayer beads

Prayer Timetable

Lota (ablutions pot)

Figure 3. Welcome Pack

Limitations

There is limited literature about Muslim experience of Western mental health services. The need for this review began by the first author noticing anecdotal experiences of Muslim patients in Scotland, and the initial focus was on UK based research to resolve a UK issue,

thereby reducing the transferability of any findings to an international audience. However, as the review progressed it moved beyond the UK as relevant literature was found from Ireland and USA, suggesting that the religious bias experienced by mental health service users was not confined to UK. We recognize further research is needed to establish the reach of the findings, but we hope that the findings will at least resonate with the experience of international colleagues. Another potential limitation, as with any interpretive research is that different researchers may have analysed the papers in different ways. The study closely followed evidence based guidance for qualitative reporting (Tong, Flemming, McInnes, Oliver, & Craig, 2012), including reflexive elements to ensure interpretations were trustworthy. Generalisability is therefore not claimed, but we are confident that the barriers to person-centred care reported here reflect the real-world experience of those described in the literature.

Conclusion

The aim of this research was to find out if mental healthcare for Muslims could be person-centred without consideration of religious identity. This review has established that it cannot, and identified four themes that help explain why:

1. The centrality of prayer, ritual and worship to Muslim patient's recovery in mental health,
2. staff anxiety, lack of knowledge, and misunderstanding of this relationship,
3. non-recording of religious needs, and
4. unconscious racial bias.

Together these themes can be explained by the existence of a novel underpinning concept: Unconscious *Religious* Bias. Research is needed on how best to effectively address Unconscious Religious Bias in nursing, but deeper knowledge of the importance of religion for minority groups is an essential first step, as the UK becomes simultaneously more secular and more multicultural.

Inequalities and disparities in healthcare have been recognised at institutional, diagnostic and front-line treatment levels. Therefore, it is imperative that any response to the delivery

of inclusive and holistic care takes place at institutional and policy level as well as at ward level.

Increased understanding could mitigate the other barriers, so a simple 'welcome pack' was introduced to facilitate this journey. The impact of any intervention needs to be evaluated, but hopefully this simple pack could signal a more welcoming and inclusive environment for Muslim patients, which in turn could reduce staff anxiety and misunderstanding. Nurses should lead the way here because this review concludes that mental healthcare for Muslim patients cannot be person-centred until the central role of religion is better understood by all members of multidisciplinary teams.

For nurses wishing to seek a basic understanding of Muslim beliefs and practices, Winter & Williams (2002) offer a useful text written in a concise and accessible style. Also, Rasool (2015) provides a valuable article on person-centred care for Muslim patients aimed specifically at nurses.

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