Our Health, Our Mind: Mental health needs in Muslim migrant and refugee communities

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Australian Muslim Women's Centre for Human Rights
Equality without Exception

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About Us

This report has been developed by the Australian Muslim Women's Centre for Human Rights (AMWCHR). AMWCHR is an organisation of Muslim women leading change to advance the rights and status of Muslim women in Australia.

We bring over 30 years of experience in providing one-to-one support to Muslim women, young women, and their families, developing and delivering community education and capacity-building programs to raise awareness and shift prevailing attitudes. We also work as advocates - researching, publishing, informing policy decisions and reform initiatives as well as offering training and consultation to increase sector capacity to recognise and respond to the needs of Muslim women, young women, and children.

As one of the leading voices for Muslim women's rights in Australia, we challenge the most immediate and pertinent issues Muslim women face every day. We promote Muslim women's right to self-Departmentermination, recognising the inherent agency that already exists, bringing issues of inequality and disadvantage to light.

AMWCHR works with individuals, the community, partner organisations and government to advocate for equality within an Australian context. This report is designed to contribute greater awareness of the unique experiences and challenges facing Muslim young people, their families, and our communities when it comes to racism and Islamophobia in Australian Schools. It is hoped that through this report and our recommendations, tangible action on racism in Victorian schools can be made.

Acknowledgements

This report recognises that gender, race, and religion intersect to create multiple forms of discrimination and violence against Muslim women, particularly in a context of growing Islamophobia. It also recognises that preventing prejudice in all forms is bound to the struggles of Aboriginal and Torres Strait Islander communities. Before we can successfully tackle issues within our communities, we must address the ongoing impacts of colonisation, systemic racism, and discrimination in all its forms in this country.

AMWCHR acknowledges the Aboriginal and Torres Strait Islander peoples of this nation. We acknowledge the Traditional Custodians of the lands our organisation is located on and where we conduct our work. We pay our respects to ancestors and Elders, past and present. AMWCHR is committed to honouring Aboriginal and Torres Strait Islander peoples' unique cultural and spiritual relationships to the land, waters, and seas and their rich contribution to society.

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Introduction

Good mental health is central to individual, collective, and community wellbeing. However, in Australia, experiences and understanding of mental health and mental health supports can be culturally, ethnically, linguistically, and religiously situated. For Muslim women, this means that mental health information and treatments must speak to these situated needs and perspectives. Currently, there is limited research focussing on Muslim women's experiences and needs with relation to mental health and healthcare in an Australian context. In response to this gap, the Australian Muslim Women's Centre for Human Rights (AMWCHR) sought to document community members' understanding of mental health and mental health issues, identify exacerbating factors and experiences, and highlight barriers to help-seeking. This Brief Report provides a summary of these key themes and findings identified through our mental health work with Muslim women. We then outline recommendations for future programs, services, and policy changes which would minimise or eliminate the barriers to good mental health that many Muslim women face.

Background

Muslim women in Australia face a unique set of challenges when it comes to preventing, recognising, and treating mental health issues. Unfortunately, the majority of mental health data in Australia is not disaggregated by religion, nor does it include participants from migrant and refugee backgrounds (Minas et al., 2013). What is known, however, is that the Australian Muslim community are at high risk of experiencing factors which contribute to poor mental health. These factors include racial, cultural, and religious discrimination, migration or displacement, housing insecurity and homelessness, financial insecurity, and poverty (Hassan, 2018; VicHealth, 2019). For young people, experiences of mental health issues are frequent and severe, with research suggesting that psychological distress levels of Australian Muslim adolescents are 34 per cent higher than non-Muslim adolescents (Kayrouz et al., 2022).

Mental health issues are also extremely prevalent in people who have recently arrived in Australia as refugees. Studies have suggested that refugees and asylum seekers experience significantly higher rates of mental health issues than the Australian-born population. Recent research has found that amongst the samples included in the studies, between 30 and 50 per cent of refugee women in Australia experience post-traumatic stress disorder (PTSD) symptoms (Khatru & Assefa, 2022; Chen et al., 2017). For those who have experienced war, conflict, and displacement, the risk of associated trauma and intergenerational trauma is high, impacting many Muslim communities, families, and individuals (Fazel, 2019). This group of women often face extreme barriers and limitations to access and participation in local and community services (Mahoney & Siyambalapitiya, 2017; Taylor, 2004), experience significant socio-economic disadvantage, have low to no literacy in any language, and can be highly isolated (Maideen & Goel, 2022). These experiences directly contribute to declining mental health as well as exacerbate existing or emerging mental health issues (Hynie, 2018).

In combination with increased risk factors, Muslim communities also experience barriers to help-seeking which can exacerbate mental health issues. Refugees and migrants in Australia have lower rates of mental health service utilisation than the Australian-born population (MHiMA, 2014). More broadly, a significant number of people from culturally and linguistically diverse (CALD) backgrounds do not seek support for mental health conditions due to a lack of information in known languages, a lack of culturally-appropriate support, a lack of knowledge about existing services, and shame or stigma (MHiMA, 2014; Tran et al., 2023). With an already overloaded healthcare system, Muslim women and young women remain at an increased risk of severe and prolonged mental health issues.

These experiences and needs have been reflected consistently throughout AMWCHR's casework and program services, as well as within our community consultations with Muslim women from diverse backgrounds. Through this feedback from community, we have become aware of the limited access to culturally relevant information on issues relating to mental health. Furthermore, since COVID, the need for capacity building and education programs for Muslim women has only increased, as more women present to our services with mental health needs. Amongst this, ongoing and emerging conflict, natural disasters, and socio-political events have had a significant impact on community members' mental health due to concerns for family and community members overseas, as well as associated rises in Islamophobia and racism in Australia. Of particular note at the time of writing is the current bombardment of Palestine. Amidst an onslaught of news coverage, and violent media and political rhetoric, reports of Islamophobia in Australia have increased 12-fold since the beginning of the crisis (Islamophobia Register Australia, 2023). The mental health impacts of this and other global crises, and the associated spikes in racism and Islamophobia, are widely visible within our programs and services as clients look for social support and solidarity.

In particular, clients seeking our casework services over the past 2 years have identified mental health issues as one of their main challenges, both in understanding the impact of mental health concerns and knowing how and where to seek appropriate support. Yet these clients are often limited in obtaining mental health support due to the lack of culturally safe and inclusive services, availability of translators, and long waiting lists to access affordable mental health care. Further, although no research has been done on this topic to date, AMWCHR practitioners have found that Muslim women, if they are able to access professional mental healthcare, often disengage after a short period. Amongst refugee and migrant populations broadly, evidence shows that a lack of continued engagement can occur for a number of reasons, including insufficient readiness related to mistrust of services, preconceptions about what treatment involves, fears surrounding confidentiality, and stigma - which can be compounded by a lack of culturally appropriate and sensitive care (Tomasi et al., 2022; Sullivan et al., 2020; Khairat, Hodge, & Duxbury, 2023). One meta-analysis of refugee and asylum seekers' experiences of individual psychological therapy, for instance, showed that treatment effectiveness and engagement was dependent on the slow building of a foundation of trust before therapeutic work could be done, as well as practitioners' high level of cultural knowledge and competency (Khairat, Hodge, & Duxbury, 2023).

Instances where a trusting therapeutic relationship was not able to form between therapists and clients led to disengagement. Experiencing a lack of cultural competency from therapists also led to relationship breakdown, impacting quality and longevity of care (Khairat, Hodge, & Duxbury, 2023).

The result of not understanding Muslim women's cultural contexts, including the work that needs to be done to create that readiness to engage, can leave clients feeling judged or misunderstood by practitioners. In the long-term, this disengagement, or reluctance to engage in the first instance, has exacerbating consequences for Muslim women's mental health issues and illnesses.

Victoria's Royal Commission into Mental Health Services recognised that the mental health system does not deliver safe, responsive, or inclusive care for people from diverse communities (DoH, 2021). AMWCHR has found this assessment of the system to be accurate and is reflected in our clients' challenges with relation to their mental health. These are complex issues that require further investigation and a tailored and community-led response. With research showing that in-language, culturally aware, community-based interventions are effective for facilitating Muslim, refugee, and migrant women's social inclusion and access to services (Amath, 2015; Mahoney & Siyambalapitiya, 2017), we believe there are opportunities to engage specialist services to fill these gaps and offer the required mental healthcare to Muslim communities.

Our Health, Our Mind: A mental health program with Muslim women

In response to this identified need in the community, the Australian Muslim Women's Centre for Human Rights delivered its Our Health, Our Mind project, a mental health program for Muslim women in Victoria. The project was designed to increase awareness and knowledge of mental health amongst diverse Muslim communities through a series of workshops with women.

The workshops focused on introducing mental health concepts, how and where to seek help, exploring migration and the impact of trauma on mental health, as well as how to identify and respond to mental health concerns in children. In total, 82 participants attended (65 women and 17 young women). All community members who attended were Muslim, and of namely Syrian, Afghan, Iraqi, South Asian and Lebanese backgrounds.

At the sessions, Program Coordinators, who facilitated the program, took detailed notes on the discussions and compiled them in workshop reports. These reports highlight participants' responses to the content, the barriers community members are experiencing when it comes to good mental health, and the coping strategies and supports they are currently utilising. The Research Coordinator also attended two of the sessions to observe. This Brief Report has been developed using the data from the workshops, collected by the facilitators and the researcher.

Findings from the workshops with Muslim refugee and migrant women

Women's understanding of and experiences with mental health issues

The women who participated in the workshops were able to name what good mental health and poor mental health looked like – from the former being characterised by family and community closeness, positive parenting, and happiness, and the latter characterised by feelings of depression, anxiety, sadness, and physical symptoms such as inability to sleep or eat, and chronic pain. They shared that community and social connection was a strong protective factor for their mental health.

Many women themselves had direct experiences of mental health issues, or had been exposed to family members' or friends' mental health issues and conditions. Some participants had diagnosed mental illnesses and had or were being treated by a mental health professional. Drivers of mental health issues were often linked to common and everyday stresses of life – finances, caring and domestic responsibilities, pressures from family, parenting challenges – as well as more severe experiences of issues related to displacement, war and conflict, settlement, Islamophobia, discrimination, and death or illness of loved ones. Several participants spoke of issues that correlated with symptoms of post-traumatic stress disorder (PTSD), such as flashbacks, vivid dreams, and environmental 'triggers' related to memories of living in a conflict zone.

Experiences of mental health challenges were also gendered. Program participants spoke of the added pressures that women had on them as wives, mothers, sisters, and daughters, and how this pressure influences their mental health. Women often felt responsible for the emotions of those around them, and felt that they should minimise their own feelings and struggles in order to manage the familial emotional environment. Some participants spoke about post-natal depression and how the difficulties of new motherhood can impact and exacerbate mental health issues, particularly when limited social and professional support is available.

These gendered expectations surrounding expression of emotions also impacted the men in participants' families and communities. Men were seen as permitted to express specific emotions, such as anger, but unable to express others, including sadness. Boys had been told from a young age that they should be 'brave', and 'strong', and these messages were reflected in how men expressed their emotions and communicated mental health struggles.

Cultural considerations when it comes to understandings of mental health

Participants of the workshops shared cultural understandings around mental health, including any norms which exist in their communities. The overwhelming theme was that participants felt that in their respective communities there was resistance towards speaking about mental health conditions and illnesses due to fears of being judged. Some participants also shared that mental illnesses were stigmatised, and in some cases slurs and insults were used to describe people who experienced mental illness.

Some participants also spoke of how religion and faith can influence their communities' understanding of and response to mental health issues. In some cases, experiencing struggles was seen as a part of 'God's will'. Even in the context of grieving the loss of a loved one, God's will may be invoked to verbalise the outward expression of this grief and the significant impact on a person's mental health that comes along with such experiences. In some cases, references to 'trust' in God and 'God's will' may be interpreted as minimising. In other cases, it may be a comfort.

It's also important to emphasise, however, that not everyone felt that naming mental health issues was a challenge in every context. These experiences were subjective and supportive environments also existed within participants lives and families.

The impacts of immigration, displacement, and migrational trauma

Migration, displacement, and settlement were viewed as significant contributors to mental health issues. Participants spoke of the stress that comes alongside moving to a new country. This stress was related to things such as difficulty learning a new language and systems, separation from family and friends back home - particularly when their safety is at risk - financial pressures, visa insecurity, and experiences of racism and discrimination. Many women spoke of the isolation and loneliness that often occurs alongside settlement, and how this impacts their mental health. The isolation was tied to the disconnection from friends and family overseas, trouble finding social connections in a new place, as well as a dependence on husbands who they rely on for transport and support navigating Australian systems. For some, the physical isolation was exacerbated by experiences of language barriers and overt discrimination or hostility when using public transport.

Several participants also spoke about how barriers to accessing education impacted their mental health, independence, and life trajectories. One participant described how not being able to pursue an education 'limits' her. Another said that the disruption to her education 'makes life harder here'. On the other hand, one participant had completed her studies, but those qualifications were not recognised in Australia. This loss of her career on top of other migrational struggles had a significant impact on her mental health and wellbeing.

Trauma was a large feature of the discussion on migration and its impacts on mental health. This included the initial trauma of experiencing conflict, war, natural disasters, and/or displacement, as well as the trauma experiences when moving to a new and unfamiliar country. Vicarious trauma was also discussed, with some naming fears and concerns for their families overseas as manifestations of vicarious trauma. Some participants also spoke about the gendered aspect of migrational difficulties and trauma. Some felt that being in Australia, the gendered expectations related to domestic duties and caring responsibilities were more difficult due to a lack of social support that they enjoyed in their home countries. Women felt more pressure to perform, and did so without the usual level of support from extended family and community networks. On the inverse, one group also discussed men's experiences of migration and how they may also experience adjustment issues surrounding their changing role in the family.

Virtually all groups expressed feeling survivor's guilt around having left their home country. These feelings were exacerbated when family members were attempting to come to Australia but were unable to, were sick or ageing overseas, or where their safety was at risk.
Although participants highlighted the many struggles that came along with settling into Australian society and how this impacted their mental health, some also wished to highlight the good that had come alongside their migration experiences. There was a wide diversity of experiences and issues that exacerbated mental health issues, which also existed alongside protective factors.

Managing mental health issues and seeking support

The women who joined the group sessions shared their existing coping strategies that they commonly reached for when their mental health was impacted. These techniques were fairly consistent across groups, and included things like spending time with and speaking to loved ones, going out into nature, listening to music, watching a movie, or doing something creative. And while some people preferred to spend time alone when they were feeling stressed or upset, others preferred to seek out social support. Participants had many methods for supporting their mental health, and had identified what did and did not work for them.

The facilitators also spoke to participants about avenues to pursue professional support for their mental health. Several participants disclosed experiences doing so themselves, with mixed results. Several issues were raised by participants which negatively impacted their experiences with accessing mental healthcare including dismissive or prejudiced attitudes from doctors, financial barriers, and a lack of cultural and religious understanding. However, the foremost issue for participants was language barriers. The lack of healthcare providers who provide services in languages other than English meant that some participants struggled to access both general practitioners – who are required to formulate a Mental Healthcare Plan – as well as counsellors and psychologists themselves.

For those who were able to access professional mental health support, these services were not in-language, and were instead provided through the support of an interpreter, which presented problems in itself. Interpreters were believed to be mis-telling or minimising women's stories, which impacted the type of healthcare they were receiving from the provider. These participants instead wished to tell their stories in their own words.

Although some participants had received professional mental health treatment, there was also disengagement from those services when the quality of treatment was not catering to participants' needs. In these cases, the facilitator as well as other group members encouraged participants to reengage and seek further treatment alongside support from the group facilitator

Additionally, it was noted that participants were not always aware of the ongoing nature of therapeutic support – namely that mental health treatment is a journey that includes multiple sessions. Many participants held the belief that treatment could be completed in 1-2 sessions with a practitioner, and were surprised when learning that recovery can take months or even years.

Providing participants with information on what is involved when accessing treatment was important to ensure that women's willingness to engage isn't diminished when their expectations differ from the reality of treatment.

The sharing of both positive and negative, challenging and rewarding experiences of accessing professional support for their mental health provided an environment for participants to open up and destigmatise treatment. It also provided an opportunity for facilitators to share existing pathways to more culturally appropriate support, where those pathways exist. Lastly – and importantly – the groups themselves, though they were not intended to be therapeutic sessions, were experienced as an alternative space to receive mental health support through community connection, the sharing of stories, and validation of both unique and shared experiences. This was especially impactful and important for those who were not ready to access mainstream one-to-one services, or who had had negative experiences with such services in the past.

Creating systems of support for Muslim refugee and migrant women

The lessons learned from the delivery of our mental health program with Muslim migrant and refugee women of diverse backgrounds are vast. It is important to remember that these sessions were intended to serve the purpose of sharing information with community members to promote understanding of mental health within community, and awareness of avenues for professional support. The facilitators were mindful that the mental health workshops were not therapeutic sessions. However, as mentioned, by virtue of the provision of a culturally and religiously safe and trusted setting, and the sharing of experiences, participants did report that the sessions helped them identify and manage their mental health stressors.

In discussing meanings and manifestations of mental health, migrational and settlement trauma, and help-seeking, participants easily resonated with the content and openly shared their own stories. The challenge for facilitators was in containing the discussion, particularly as the workshops were primarily focussed on awareness raising and information sharing. And in fact, participants expressed a desire to return for more sessions - such was the level of engagement and willingness to share in a group setting.

It was clear from participants' responses to the program that initial hesitancies with opening up about mental health were soon overcome once attendees became more familiar with the group and felt they were in a safe and trusted environment. This factor of the workshops is again demonstrative of how this modality supported engagement, learning, and sharing. The provision of an environment where women were able to listen to others' stories – which often mirrored their own – diffused many of the hesitancies and taboos that participants felt prior to attending. This provided a judgement-free space to speak openly about their own struggles, and facilitators took opportunities to engage with participants one-on-one at the close of the workshops if they identified women as requiring additional support or debriefing. The trust that had been developed between participants as well as with the facilitators meant that women were more open to engaging further with referred services.

Evidently, the community members who attended the mental health workshops had diverse experiences, realities, and barriers to good mental health. However, there were several themes that emerged throughout discussions with each group. These included:

- Existing norms may be preventing open discussion of mental health issues: Although participants were able to express what mental health looked like, and how mental health issues had impacted them and their loved ones, there remained stigma and taboo in many people's communities surrounding disclosure and discussion of mental health conditions. Alongside other barriers, these norms contributed to a lack of readiness to engage with more formal supports available.

- Gendered pressures, Islamophobia, and discrimination are impacting Muslim women's mental health: Experiences of mental health issues were seen to be gendered. Women's mental health was impacted by domestic and familial responsibilities, physiological factors, and pressures related to emotional labour. At the same time, experiences of interpersonal and systemic Islamophobia, racism, and discrimination were both causal factors for poor mental health, as well as compounding factors when experienced in the context of help-seeking.

- Migration, displacement, and subsequent settlement are key drivers of mental health conditions: Experiences of mental health issues tied to migration and displacement, and subsequent settlement in Australia were common and severe. Experiences of trauma, loneliness, isolation, discrimination, and social disconnection in the context of settlement are significant contributors to mental health issues.

- Support services for refugee and migrant Muslim women are inaccessible, low-quality, or unsuitable: Despite many participants disclosing serious issues impacting their mental health, gaining access to culturally and linguistically appropriate, affordable, and effective professional support was challenging. Although positive experiences were shared, most participants had either never attempted to access professional support themselves, or if they had, faced barriers or inadequate support. The poor service quality for this community directly contributed to patient disengagement. These results suggest that traditional mental health supports may not be suitable for many Muslim migrant and refugee women in their current form.

It is clear from our engagement with community that Muslim women are open to speaking and engaging more on the topic of mental health. However, access to appropriate formal and informal supports is limited. The outcomes and documented learnings from these programs contribute critical insight to inform future programs and services in the mental health space. Furthermore, this report offers a series of recommendations to support practitioners, the mental health sector and government more broadly, and to offer our learnings as a tool for strengthening mental health response.

Recommendations:

The following recommendations are provided to address barriers to access and engagement with mental health supports and to enhance the quality and appropriateness of available supports to better cater to the needs of Muslim migrant and refugee women and young women.

1. Provide sustained funding for community-based supports for mental health

Community based programs should be adequately resourced by government, given that we know community support and connectedness is a primary protective factor for mental health in refugee and migrant communities (WHO, 2023). To facilitate good mental health in Muslim communities, including for those impacted by migration and displacement, preventative measures and funding should focus on creating community spaces and programs to build up protective factors.

Multicultural and ethno-specific services should be prioritised in funding rounds, in recognition of the high quality of culturally relevant services being delivered by these organisations, despite low and insecure funding compared to mainstream services (Mansouri, Weng, & Vergani, 2022). Funding should prioritise multi-year or ongoing funding over shorter-term project-based funding, recognising that sustained presence and engagement at a community level is required to effectively shift social and cultural attitudes and to strengthen individual and community capacity and resilience to address mental health issues. The sustained funding of community prevention programs will also contribute to the normalisation of speaking about and centring mental health within Muslim communities more broadly. In the long-term, this will ensure that Muslim women's mental health prevention and support needs are holistically addressed.

2. Increase access to and supply of multicultural, multilingual mental health professionals

To address barriers to accessing multilingual mental health professionals, including those from Muslim backgrounds, governments and the mental health sector should implement the following:

a) Incentives for diverse Australians to pursue qualifications in the mental health space. This might include significantly increased scholarships and fee subsidies/offsets.

b) Increased government funding for multicultural mental health services.

c) Internal reviews of mainstream services' hiring policies and practices to ensure no systemic barriers towards diverse staffing of their organisations exist.

d) Governmental review of laws and regulations around the lack of recognition of overseas mental healthcare qualifications towards the creation of efficient and accessible systems for upskilling and retraining overseas accredited workers.

e) Addressing financial costs associated with seeking psychological support. This could be done through increasing the number of Medicare-subsidised psychology sessions from 10 per calendar year to 20 per calendar year.

3. Provide options for therapeutic group-based mental health support

Increased funding for intensive, in-language mental health group-based support programs. This model will support the normalisation of speaking openly about mental health within a context where one-to-one support may feel intimidating, while also providing an element of social support and connectedness for those who may not have access to strong social supports in Australia. This will also have the effect of creating readiness to engage with the wider mental healthcare system if individuals require more intensive and ongoing treatment.

4. Provide training to mental health service providers to increase cultural capacity to support Muslim migrant and refugee women and families

Individual mental healthcare services should consult with and engage subject matter experts from diverse services to ensure their policies, staffing, and delivery is culturally appropriate and impactful for the communities they service. Staff training on working with diverse Muslim migrant and refugee communities will build the capacity of practitioners and services to provide equitable and intersectional practice and support cultural safety for clients accessing these services. Such capacity building and consultation will minimise client disengagement from seeking mental health support as a result of gaps in culturally literate service providers or ineffective support.

5. Increased collaboration and referral pathways between multicultural services and the mental healthcare sector.

Referral pathways to culturally and linguistically appropriate, affordable, and accessible mental health services should be built between multicultural services and the mental healthcare sector. Partnered delivery of mental health programs to this cohort will create pathways from more informal or group-based therapeutic interventions towards one-to-one clinical support, where this support is needed.

6. Increase the evidence base on prevention and intervention initiatives that work for Muslim migrant and refugee women

Data on mental health outcomes for Muslim communities are not generally collected. Instead, Muslim mental health data is generally gathered under the 'CALD' umbrella. Specific research on mental health outcomes, literacy, and the effectiveness of public health measures in Muslim communities is required to reflect the unique experiences of many diverse cultures within Muslim communities, including the impacts of Islamophobia and the ongoing politicisation of Muslim women. Government services should ensure that mental health data is disaggregated not only by gender, ethnicity, and language, but also by other variables including religion. This data should be used within research, including through secondary analysis, as well as within government policy development to highlight and address issues of inequity impacting Muslim communities. Governments should also commission or fund research and evidence building focussed on Muslim women's mental health, including preventative and exacerbating factors and the interventions that work.

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