ABOUT THE RESEARCH

Both religious and nonreligious worldviews offer frameworks and ways of making sense of the experiences and phenomena that get referred to as mental illness. However, with the exception of limited pastoral support provided through chaplaincy services, which remain heavily Christian dominated (i), psychology and mental healthcare in the UK largely operates according to a medical model that preserves colonial configurations. Mental healthcare service delivery might therefore be seen as reflecting values most often associated with whiteness (ii) and nonreligious or secular worldviews. These are values that are not neutral (iii), and do not necessarily support equitable or inclusive service delivery.

Religions and spiritualities – especially those outside of white-dominant Christian worldviews, or secularised versions of mindfulness – are often neglected altogether within mainstream psychology and mental healthcare. This is despite the reality that approximately 90% of the world's population participate in some form of religious or spiritual practice (iv). Further, it remains the case even though 'religion' and 'religious belief' has, for better or worse, been historically associated and linked with 'pathological psychotic states' including 'hysteria', 'neurosis' and 'psychotic delusions'. This association has arguably resulted in negative outcomes for those seeking and/or in receipt of care during periods of emotional and mental distress(v).

Advancing the public understanding of religious and nonreligious worldviews is central in the desire to create a more just, equitable, inclusive society.

Within mental healthcare greater religious literacy, alongside racial and cultural literacy, has the potential to support better mental health outcomes and reduce pressure on an overburdened NHS.

References

i. Ryan 2015; NPSRCH 2020
ii. Yancy 2008 & 2015; Kinouani 2019 & 2021
iii. Dinham & Jones 2010; Dinham & Francis 2015
iv. Koenig 2009; Swinton 2001
v. Koenig 2009; Rasheed 2010; Grover et al 2014

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Notwithstanding the real and evidenced potential for religion and religious communities to be a source of trauma and suffering, there remain challenges rooted in the failure to engage intentionally with the ways in which religious and spiritual beliefs might be positively associated with health.

Existing challenges include that we currently have a very limited evidence base pertaining to how 'religion' and particular 'religious communities' offer potential resources both for individuals and communities facing particular mental health related challenges (vi). Specifically, we don't know enough about how:

- particular worldviews might be protective and help people to cope during experiences of emotional distress;
- religious communities might provide a sense of belonging for individuals and groups during times of distress;
- religious communities and leaders may act as a channel through which to ensure the delivery of more equitable, effective and holistic mental healthcare (vii).

RESEARCH CONTEXT

It is important that mental healthcare services reflect the real religious and ethnic landscape of Britain's diverse and pluralistic society. In the current context, it is perhaps especially important to consider the experiences of racially and religiously minoritised and excluded individuals and groups (i.e. 'BAME', 'People of Global Majority' groups, and Black groups). These groups are:

- more likely to have a long-term health condition;
- overrepresented among people with severe mental illness;
- more likely to be in-patients and experience compulsory hospital admission (viii)
- more likely to experience distress and/or experience an exacerbation of existing mental health conditions on account of discrimination (ix).

These individuals and groups are also far more likely to hold worldviews in which treating professionals may not be literate (e.g. African indigenous beliefs).

References

vi. Campbell 2021
vii. Taylor et al 2000; Whitley 2012; Mantovani et al 2017; Mouzon 2017; Hope et al 2020; Assari & Moghani Lankarani 2018; Codjoe et al 2019)
viii. Bhui et al 2003; Boydell et al. 2013; Guy's and St Thomas' Charitable Trust 2018; Codgoe et al 2019; Kinouani in Watson 2019; Mind 2020; Kinouani 2021; Creasy et al 2021; Rethink Mental Illness 2021
ix. Williams et al., 2003 ; Pascoe & Smart Richman, 2009; Johnston & Lordan, 2012; Hatch et al 2016; Creary et al 2021; Kinouani 2021

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POLICY & PRACTICE IMPLICATIONS

We know that questions about religion and worldviews and wellbeing are really important across society; but also specifically within schools settings, both for pupils and staff.

According to research from Young Minds, 1 in 8 children have a diagnosable mental health 'disorder' (x). This amounts to roughly 3 children in every classroom. Furthermore, the experiences of children of school age are extremely significant when it comes to longer term mental health outcomes. Adults who experienced four or more adversities in their childhood are four times more likely to have low levels of mental wellbeing and life satisfaction (xi). 1 in 3 adult mental health conditions relate directly to adverse childhood experiences (xii).

These statistics emphasise the important role of schools in ensuring health and wellbeing of pupils, who will go on to be the workers of the future. They also highlight the role the educational professionals and policy makers can play in supporting inclusive and equitable understandings of religious and nonreligious worldviews within efforts to ensure staff and student support wellbeing within the life of the school and beyond.

Schools and teachers are uniquely placed to advance the public understanding of religious and nonreligious worldviews, and model and inculcate the values of equity, justice and inclusion as part of efforts to build a more open, inclusive and respectful society. This research therefore emphasises the need for holistic, whole school approaches to engaging with religious and nonreligious worldviews that also take account of the experiences of both pupils and staff and their wellbeing.

References

x. NHS Digital 2018
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xii. Mehta et al 2013

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This briefing calls for policy changes in order to harness the following opportunities:

SCHOOL LEADERSHIP: Training for school leadership, governance and staff to enhance understandings of religious and nonreligious worldviews in schools and beyond. This includes ensuring adequate safeguarding measures to protect against related forms of bullying, harassment and discrimination for marginalised individuals and groups.

SCHOOL CULTURE: Policies and practices that reflect a critical focus and engagement with religion and worldviews alongside other 'protected characteristics' such as race, gender or sexuality. This should support existing efforts towards equitable and inclusive school cultures free from bullying and harassment, which can lead to poor mental health outcomes.

TEACHER TRAINING: Support to ensure teachers are equipped to engage critically, sensitively and effectively with a range of religious and nonreligious worldviews across a diverse range of subjects; The development of knowledge, skills, and confidence to tackle issues of discrimination and 'microaggressions' that lead to poor wellbeing and mental health outcomes for staff and pupils in the classroom.

CURRICULA REFORM & DEVELOPMENT: Curricula that reflect and support critical engagements with a range of religious and nonreligious worldviews using a range of pedagogical approaches and methods; Learning that ensures pupils are equipped to engage sensitively and effectively with people from religious and nonreligious backgrounds; Learning that ensures pupils become reflexive and self-aware members of society, mindful of their own worldviews and their effect on actions, decisions and social interactions.

RELIGIOUS EDUCATION: Ensuring every young person experiences an academically rigorous and personally inspiring education in religion and worldviews, contributing to their capacity to be well-informed and respectful members of society.

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