COMMUNITY ENGAGEMENT PROJECT

Under the NIMHE Mental Health Programme

REPORT OF THE COMMUNITY LED RESEARCH PROJECT BY BINOH OF MANCHESTER Focussing On Mental Health Service Needs Amongst The Orthodox Jewish Community In Greater Manchester

DEAN COWAN
SIMON GRANT
MIRIAM LOCK
SHOLOM SALZMANN
ANN SLADE

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BINOH/הניב

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The Centre for Ethnicity and Health, University of Central Lancashire.

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THE PROJECT TEAM

The following people were involved in the development and delivery of this project:

Dean Cowan – 47 years old. Dean, a senior project researcher, has a background in policy and strategy mainly in the fields of public and voluntary sector housing. He has post graduate qualifications in social policy and an M.A. in Cultural Studies. He is currently employed as a professional diversity and training officer for Rochdale C.V.S.

Simon Grant – 43 years old. Binoh's Director of Services, is responsible for running its various community services. As the project 'anchorman', he has directed the stages of the project's organisation, design and delivery. Although a Social Sciences graduate (many years ago!), this project has renewed his interest in community research and mental health.

Miriam Lock – 33 years old. Miriam a community volunteer recruited to the project has a B.A. in Psychology from the Open University. She assisted in facilitating a focus group with women in the community and transcribing the feedback. She used the project to obtain a certificate in Mental Health Research from the university.

Sholem Salzman – 56 years old. Sholom, a senior project researcher, has extensive experience in the field of mental health having been a hostel manager for a leading Jewish Housing Association in London and several years experience as a Mental Health Act Advocate and Manager. He has also used the project in order to obtain a certificate in Mental Health Research from the university

Ann Slade – 45 years old. Ann has a background in the field of mental health research having worked for St. Mary's Hospital and The City of Westminster Social Services as an administrator for an academic research project on 'Care in The Community'. She is currently a full time mother and a part time nursery teacher.

ACKNOWLEDGEMENTS

As with every large community project numerous individual and groups have given of their time, knowledge and expertise in order to make the project a success. Therefore it would seem unfair, if not invidious, to single out certain individuals. Nevertheless the project team feel it would be remiss of them and would leave the report incomplete if they were not to acknowledge certain key people who have particularly supported the work of the project.

The project team would, therefore, particularly wish to acknowledge the contribution of:

- The members of the Project Steering Committee, Cathy Riley, Debra Carson, Alex Silverstone, Norman Younger and Sam Portnoy, who, despite their crowded schedules, recognised the project's importance by unstintingly giving of their time, knowledge and experience to make this project a success.

- Manjeet Singh Regional Race Equality Lead for The Care Services Improvement Partnership who generously assisted us with the project's research and development and was available to lend her considerable knowledge of ethnic minority mental health issues to the project.

- Myer Heilpern Binoh's Chairman who has supported the project and always been willing to both advise and guide the project.

- Valerie Chawla our dedicated support worker whose professionalism, dedication and knowledge were vital to the project's entire success.

- The University Teaching Staff who through their unparalleled academic expertise have guided and enlightened us throughout all the stages of the project.

- Eileen Jackson the Project Administrator in The University who with her usual politeness and efficiency has always been willing and available to deal with our queries and needs.

- Alan Wellins Human Resources Programmes Implementation Manager for IBM (U.K.), Chairman of The Salford Orthodox Jewish Community Forum and a tireless community activist who expended his considerable professional knowledge to assist us with the creation and compilation of the questionnaire data capture sheets.

- Stephen Wilson Director of Agudas Yisroel Employment and Community Services who spent considerable time and effort computing the questionnaire data and compiling the project data and tables.

- And lastly to all the people who completed the questionnaires, attended the focus groups and agreed to be interviewed; without you this simply couldn't have happened.

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EXECUTIVE SUMMARY

This Community Needs Assessment Survey is part of a nationwide programme sponsored by the National Institute for Mental Health in England (NIMHE) awarded and administered by the Centre for Ethnicity and Health at The University of Central Lancashire. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to current and future provision of mental health support services. Through this programme invaluable facts and data has emerged around the specific mental health needs of a wide range of ethnic community groupings in the United Kingdom.

The project was undertaken by Binoh of Manchester amongst its client group, The Orthodox Jewish Community of North Manchester. This is mainly based in the Broughton Park area of Salford with an overspill community in the neighbouring Bury and Manchester metropolitan areas. The community is ethnically compact, little known outside its location and buffeted by racial and economic problems. Different norms exist for acceptable music, literature, images and discussion material and mainstream culture i.e. television, films, magazines and internet use etc. is prohibited. The community's growth over the last few years has been huge. High birth rates make the community 'bottom heavy', and it is estimated that the ultra-orthodox community is increasing its share of the Anglo-Jewish community by approximately 1.5% per year.

A group of community researchers and volunteers with experience in both community engagement and mental health support was recruited to undertake the project under the guidance and supervision of the university and its academic staff. The principal methods of information gathering and data collection were:

- Questionnaires distributed within the community (64 were returned and completed).
- Two focus groups (one with ladies and a second with teenagers) totalling some 30-40 participants.
- Ten in depth interviews with practitioners, carers and those with mental health needs.

The research uncovered a wealth of information that is central to understanding the mental health needs and concerns of the Orthodox Jewish Community. The foremost findings that emerged during the research were:

- A distrust of non-Jewish professionals e.g. doctors, psychiatrists and nurses who were seen to be unsympathetic or ignorant of the community's cultural and religious needs. Comments such as "most Non-Jewish Practitioners have no understanding of our community and therefore can make serious errors of judgement" were commonly made.

- Fear of stigma attached to mental health issues. Although this is prevalent in many close knit and ethnic minority communities this was particularly prevalent within the community as it was associated with not obtaining suitable marriage partners for themselves, siblings, children or other family members. One questionnaire respondent even said that "stigma within the community is a greater concern to people requesting and accepting help (than gaps in current service provision)".

The report makes four primary recommendations:

1) The need for relevant professionals to undergo ethnicity training

This is felt to be critical towards relevant and effective service design and delivery and accurate professional judgements concerning the Orthodox Jewish Community. Such a holistic approach is especially relevant when working with a group such as The Orthodox Jewish Community whose ethos covers all aspects of members' behaviour including religious life, home life, inter-personal relationships, business and community life.

2) The need for community based mental health workers

This could be linked to the 'Delivering Race Equality' Programme to fund the employment of a Community Development Worker with a specific function to work inside The Orthodox Jewish Community. Whilst there have been difficulties in the rolling out of the initiative and only just under a third of posts have been filled there has been strong government backing for the idea. Rosie Winterton The Minister of State (Health Services) in The Department of Health sent a strongly worded letter last year to all Primary Care Trust Chief Executives Health reminding them of their obligation to undertake the programme. Professor Louis Appleby The National Director for Mental Health has recently stated in an essay on Reaching Out To Ethnic Minority Communities that "we're determined that the other 340 (Community Development Workers) will appear as well".

3) The establishment of a mental health community supported employment project

Supported Employment is a well-defined approach to helping people with mental illnesses find and keep competitive employment within their communities. Supported employment programs are staffed by employment specialists who have frequent meetings with treatment providers to integrate supported employment with mental health services. Participants would complete an evaluation to identify their interests and skills and thereby allowing suitable job matches. Professional support services including case management, counselling, social support and leisure activities would be provided for participants along with relevant employment development programmes.

The ‘Community Cohesion Review Team’ headed by Dr. Ted Cantle created after the serious Northern inner city race riots of 2000-1 concluded that a major source of the riots was the lack of contact between disaffected ethnic minority young people and their white counterparts and the resentment created by exclusive funding projects. It criticised ethnic sensitive provision as promoting jealousy and racial segregation and weakening community cohesion thereby creating a potentially explosive situation. In its conclusions the report recommended that there should be (Cantle 2002) “a presumption against single group funding”.

Despite this the team feel that the need for an ethnically sensitive support system is overwhelming especially in such a vital area as mental health support services. The Orthodox Jewish Community with its distinctive lifestyle, culture and beliefs is clearly a distinct and identifiable community. An ‘inclusive’ service will by its nature become exclusive as it will exclude the culturally distinct who will not access universal services. Paradoxically it is only by being flexible about the funding of exclusive services that true inclusivity can be achieved. In the final analysis the project team believe that if a conflict exists between preserving a millennia old way of life and belief system and the possibility of accessing wider resource services the former will inevitably emerge successful.

4 Increased community education and awareness of mental health issues and well being

The community’s particular stigmas concerning mental health issues (detailed elsewhere in the report) and the need for ethnically sensitive literature and materials have inevitably led to a considerable lack of awareness around mental health issues. To counter this phenomenon it is necessary to undertake work within the community around these issues. Similar campaigns have been undertaken in the past by professionals who understand the community’s needs and with the signed approval of rabbinic leaders. These have successfully heightened the community’s awareness in a range of different issues e.g. cervical cancer, crime prevention etc. There is strong cause for optimism that a carefully planned series of informatory meetings could successfully raise community awareness and allow people to adopt successful preventative measures.

The Greater Manchester Orthodox Jewish Community has an estimated annual growth rate of 7%. The influx of new members from abroad coupled with various new housing projects will only accelerate this trend. With current government estimates that up to 20% of the population will suffer mental health difficulties sometime during their life, the issues and challenges detailed in this report will rise steeply in the coming years. It is up to service planners to take bold decisions to support culturally sensitive services to help those who are bypassed by current services and provisions. The consequences of ignoring this need are too worrying to contemplate for the people most affected, the local Jewish Community and indeed the entire population of Greater Manchester.

INTRODUCTION

The Centre for Ethnicity and Health's Model of community engagement

Background to the community engagement model

We often hear the following words or phrases:

- Community consultation.
- Community representation.
- Community involvement/participation.
- Community empowerment.
- Community development.
- Community engagement.

Sometimes these terms are used inter-changeably; sometimes one term is used by different people to mean different things. The Centre for Ethnicity and Health has a very specific notion of community engagement. The Centre's model of community engagement evolved over several years as a result of its involvement in a number of projects. Perhaps the most important milestone however came in November 2000, when the Department of Health (DH) awarded a contract to what was then the Ethnicity and Health Unit at the University of Central Lancashire (UCLAN) to administer and support a new grants initiative. The initiative aimed to get local Black and minority ethnic community groups across England to conduct their own needs assessments, in relation to drugs education, prevention, and treatment services.

The DH had two key things in mind when it commissioned the work; first, the DH wanted a number of reports to be produced that would highlight the drug-related needs of a range of Black and minority ethnic communities. Second, and to an extent even more important, was the process by which this was to be done.

If all the DH had wanted was a needs assessment and a 'glossy report', they could have commissioned researchers and produced yet another set of reports that may have had little long term impact. However this scheme was to be different. The DH was clear that it did not want researchers to go into the community, to do the work, and then to go away. It wanted local Black and minority ethnic communities to undertake the work themselves. These groups may not have known anything about drugs, or anything about undertaking a needs assessment at the start of the project; however they would have proven access to the communities they were working with, the potential to be supported and trained, and the infrastructure to conduct such a piece of work. They would be able to use the nine-month process to learn about drug related issues, and how to undertake a needs assessment. They would be able to benefit and learn from the training and support that the Ethnicity and Health Unit would provide, and they would learn from actually managing and undertaking the work. In this way, at the end of the process, there would be a number of individuals left behind in the community who would have gained from undertaking this work. They would have learned

about drugs, and learned about the needs of their communities, and they would be able to continue to articulate those needs to their local service providers, and their local Drug Action Teams (DATs). It was out of this project that the Centre for Ethnicity and Health's model of community engagement was born.

The model has since been developed and refined, and has been applied to a number of areas of work. These include:

- Substance misuse.
- Criminal justice system.
- Policing.
- Sexual health.
- Mental health.
- Regeneration.
- Higher education.
- Asylum seekers and refugees.

New communities have also been brought into the programme: although Black and minority ethnic communities remain a focus to the work, the Centre has also worked with:

- Young people.
- People with disabilities.
- Service user groups.
- Victims of domestic violence.
- Gay, lesbian and bi-sexual and trans-gender people.
- Women.
- White deprived communities.
- Rural communities.

In addition to the DH, key partners have included the Home Office, the National Treatment Agency for Substance Misuse, the Healthcare Commission, The National Institute for Mental Health in England, the Greater London Authority, New Scotland Yard and Aimhigher.

The key ingredients of the model

According to the Centre for Ethnicity and Health model, a community engagement project must have the community at its very heart. In order to achieve this, it is essential to work through a host community organisation. This may be an existing community group, but it might also be necessary to set up a group for this specific purpose of conducting the community engagement research.

The key thing is that this host community organisation should have good links to the defined target community1, such that it is able to recruit a number of people from the target community to take part in the project and to do the work (see section on task below).

It is important that the host community organisation is able to co-ordinate the work, and provide an infra-structure (e.g. somewhere to meet; access to phones and computers; financial systems) for the day-to-day activities of the project. One of the first tasks that this host community organisation undertakes is to recruit a number of people from the target community to work on the project.

The second key ingredient is the research task that the community undertakes. According to the Centre for Ethnicity and Health model, this must be something that is meaningful, time limited and manageable. Nearly all of the community engagement projects have involved communities in undertaking a piece of research or a consultation exercise within their own communities. In some cases there has been an initial resistance to doing 'yet another piece of research', but this misses the point. As in the initial programme run on behalf of the DH, the process and its outcomes have equal importance. The task or activity is something around which lots of other things will happen over the lifetime of the project. Individuals will learn and new partnerships will be formed. Besides, it is important not to lose sight of the fact that it will be the fist time that these individuals have undertaken a research project.

The final ingredient, according to the Centre for Ethnicity and Health's model, is the provision of appropriate support and guidance. It is not expected that community groups offer their time and input for free. Typically a payment in the region of £15-20,000 will be made available to the host organisation. It is expected that the bulk of this money will be used to pay people from the target community as community researchers2. A named member of staff from the community engagement team is allocated as a project support worker. This person will visit the project for at least half a day once a fortnight. It is their role to support and guide the host organisation and the researchers throughout the project. The University also provides a package of training, typically in the form of a series of accredited workshops.

The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers

[1] The target community may be defined in a number of ways – in many of the community engagement projects it has been defined by ethnicity. We have also worked with projects where it has been defined by some other criteria, such as age (e.g. young people); gender (e.g. women); sexuality (e.g. gay men); service users (e.g. users of drug services or mental health service users); geography (e.g. within a particular ward or estate) or by some other label that people can identify with (e.g. victims of domestic violence, sex workers).

[2] This is not always possible, for example, where potential participants are in receipt of state benefits and where to receive payment would leave the participant worse off.

will also assist the group to form an appropriate steering group to support the project3.

The steering group is an essential element of the project: it helps the community researchers to identify the community they are engaging with, and can also facilitate the long term sustainability of the projects recommendations and outcomes. The community researchers undertake a needs assessment or a consultation exercise. However the steering group will ensure that the work that the group undertakes sits with local priorities and strategies; also that there is a mechanism for picking up the findings and recommendations identified by the research. The steering group can also support individuals' career development as they progress through the project

The community engagement team

The community engagement team comprises of senior support workers, support workers, teaching and learning staff, administration team and a communications officer. They work across a range of community engagement areas of specialisation, within a tight regional framework.

<table>
<tr><td colspan="4">National Programme Directors</td></tr>
<tr><td>Northern Team</td><td>Midlands Team</td><td>Southern Team</td><td rowspan="2">Senior Programme Advisors</td></tr>
<tr><td colspan="2">Senior Support Worker</td><td>Senior Support Worker</td></tr>
<tr><td>Support Workers</td><td>Support Workers</td><td>Support Workers</td><td>Drug Interventions Programme</td></tr>
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<tr><td colspan="4">Teaching And Learning Team</td></tr>
<tr><td colspan="4">Administration Team</td></tr>
<tr><td colspan="4">Communications Officer</td></tr>
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Programme outcomes

Each group involved in the Community Engagement Programmes is required to submit a report detailing the needs, issues or concerns of the community. The qualitative themes that emerge from the reports are often very powerful. Such information is key to commissioning and planning services for diverse and 'hard to reach' communities. Often new partnerships between statutory sector and hard to reach communities are formed as a direct result of community engagement projects.

[3] Very often we will have helped groups to do this very early on in the process at the point at which they are applying to take part in the project.

In 2005/-6 the Substance Misuse Community Engagement Programme was externally evaluated. This concluded that:

- The Community Engagement Programme had made very significant contributions to increasing awareness of substance misuse and understanding of the substance misuse needs of the participating communities. It also raised awareness of the corresponding specialist services available and of the wider policy and strategy context.

- The Community Engagement Programme had enabled many new networks and professional relationships to be formed and that DATs appreciated the links they had made as a result of the programme (and the improvements in existing contacts) and stated their intentions to maintain those links.

- Most commissioners reported that they had gained useful information, awareness and evidence about the nature and substance misuse service needs of the participating organisations.

- All DATs reported positive change in their relationship with the community organisations. They stated that the Community Engagement Programme reports would inform their plans for the development of appropriate services in the future.

- A significant number of the links established between DATs and community organisations as part of the Community Engagement Programme were made for the first time.

- The majority of community organisations reported their influence over commissioners had improved.

- Training and access to education was successful and widely appreciated. 379 people went through an accredited University education programme.

- A third of community organisations in the first tranche reported that new services had been developed as a result of the Community Engagement Programme.

- The vast majority of participants and stakeholders expressed high levels of satisfaction with the project.

The capacity building of the individuals and groups involved in the programme is often one of the key outcomes. Over 20% of those who are formally trained go on to find work in a related field.

The Project Team would like to state at the commencement of this report that the views expressed in the report are entirely those of the group that undertook the work, and are not necessarily those of The Centre for Ethnicity and Health at the University of Central Lancashire, The National Institute for Mental Health in England (NIMHE) or The Binoh Management Committee.

THE BINOH REPORT

DEMOGRAPHICS

Brief Analysis of the Orthodox Jewish Community in North Manchester

Binoh is based in The City of Salford where severe economic dislocation caused by the decline in mining and other 'heavy' industries has created many severe urban challenges. Unemployment is significantly higher than the regional average, recorded crime is 30% higher than the national average and twice as many households live in council housing than the national average. Overall Salford is ranked the 12th most deprived Local Authority Area in England and Wales. It is, however, unusual in that it has a small ethnic minority community and in The 2001 Census 96.1% of the population classed themselves as white as opposed to 90.9% nationally. The largest racial group reported was Orthodox Jewish (2.4%) double that of the next ethnic grouping (Muslim). Since 2001 there has, however, been an influx of both African asylum seekers and Central-European economic migrants and a recent Salford Diversity Forum reported over twenty languages spoken in The City.

The Orthodox Jewish Community is a compact ethnic group, little known outside its area and buffeted by racial tensions. Two recent surveys showed high unemployment (18% of males not in employment) and reported that:

- 59% of households receive at least one benefit (excluding child benefit)
- 52% of respondents could not afford two items defined as 'essential'
- 39% of households cannot afford to replace worn out furniture.

Age distribution is skewed towards under 25s (48% are under 15) with an average family size of 7-8 children, many of whom speak English as a second language. The religious school system places children outside L.E.A. provision and employment provision is restrictive. A recent Prince's Trust report described the area as harbouring "extremely high levels of need".

The OJC has now spread to the area of Prestwich which is in the Borough of Bury. This community is rapidly growing and is composed mainly of large families. Anecdotally the population is though to be half the size of the OJC in Broughton Park and is made up mainly of younger families also with higher than average number of children per home. Demographic data is only available from the census of 2001 and there has been tremendous growth in the population since then making these figures particularly unreliable.

Review of Background material relevant to the research project

The bid for this research was based on the Holman Report, “The Orthodox Jewish Community in ‘Broughton Park’ – a study” by Christine and Naomi Holman, June 2003. In their research they demonstrate clearly that less than 1% of the community would consider consulting a non-Jewish organisation in the case of a personal crisis.

In order to understand the lack of take-up of services by the OJC, the researchers utilised three earlier reports: the Stephen Lawrence Enquiry, the David Bennett enquiry and the Scarman Report.

Failure to be proactive in community engagement was one of the severest criticisms of the mental health services generally by Black and Ethnic Minority Communities (BMEs) as evidenced by the Bennett Enquiry 1998, the Stephen Lawrence Enquiry 1993 and the Scarman Report 1981 into the cause of the Brixton Riots.

However, it was the first two enquiries that were most pertinent to our own investigation. Firstly the Stephen Lawrence Enquiry conducted after the murder and faulty investigation into the death of the black teenager Stephen Lawrence, introduced the concept of institutional racism by the police and other services when dealing with crimes involving the Black Community. The David Bennett Enquiry which was conducted after the accidental death of a Black mental health patient in a secure mental health hospital after an alleged racist incident with another patient.

Both reports highlight faults in institutions created to protect and treat us with due regard to both individual and diverse needs. What the reports focussed on was unintentional practices which socially excluded Black and ethnic minorities from equitable service delivery in both cases resulting in suspected miscarriages of justice (Lawrence) and accidental death (Bennett).

Social Exclusion and the Orthodox Jewish Community.

Building on the work of the Holman Report and with the Bennett Report particularly in mind the researchers employed by Binoh tackled the problem of social exclusion from the position of not outright discrimination against the community in the form of Anti-Semitism and religious intolerance but from the position of relative invisibility and a lack of knowledge about the community’s religious and social needs when assessing their requirements for services.

What Binoh has sought to investigate is whether the needs of the OJC were neglected due to the mutual conditions of lack of visibility of the OJC to the service providers and lack of community engagement by the service providers. Services provided tend to be responsive; if patients from within the community do not come forward for services the services have nothing to respond to.

The Focus of this Report

Since 2000 over 200-community groups have taken part in one or other of the Centre for Ethnicity and Health's Community Engagement Programmes.

Binoh of Manchester were one of 40 community groups who took part in the National Institute for Mental Health in England's Community Engagement Programme between 2005 and 2007. The objectives of the programme were to deliver and improve equality of access, experience and outcomes for Black and minority ethnic mental health service users by:

- Building capacity in the non-statutory sector.
- Encouraging the engagement of Black and minority ethnic communities in the commissioning process.
- Ensuring a better understanding by the statutory sector of the innovative approaches that are used in the non-statutory sector.
- Involving Black and minority ethnic communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services.
- Ensuring greater community participation in, and ownership of, mental health services.
- Allowing local populations to influence the way services are planned and delivered.
- Contributing to workforce development, and specifically the recruitment of 500 Community Development Workers.

The Specific Focus of Binoh's report was focussing upon Mental Health Service Needs amongst the Orthodox Jewish Community (OJC) In Greater Manchester and specifically the accessibility of Mental Health Services to the community.
The research statement of this project was: 'Are the statuary service providers offering a culturally sensitive and appropriate mental health service to the Orthodox Jewish Community in Manchester'?

Specific questions raised by the research aims and earlier research were;

Is the low uptake of Mental Health Services by the OJC due to

a) This minority community having less need of mental health services than the general population?
b) This minority community having the same level of need as the general population, but having this need successfully met from within the community?
c) This minority community having the same level of need as the general population, and not having the need being met, but the need being invisible to the service providers.

METHODS

With the very specialist thrust of the project around Community Mental Health Provision, the Binoh Executive Committee took, at an early stage, a strategic decision to recruit a Project Team with experience both in community engagement and community mental health support. To this end two of the project team had in depth, professional knowledge of Community Mental Health support one of them being a Mental Health Act Manager with working experience in both London and Manchester. This decision was farsighted and was vindicated by the expert advice and input that these individuals were able to contribute to the project and the unparalleled links that they possessed and were able to forge with mainstream service providers and community health professionals. Working with colleagues possessing experience in community engagement and social policy a project team was formed combining an unusually high standard of expertise, knowledge and leadership. Apart from the Project Director and Principal Researchers, community publicity successfully lead to the team being widened to include three community volunteers.

The Project Team was coordinated and directed by Rabbi Grant, Binoh's Director of Services who had undertaken a similar role three years' earlier during Binoh's previous Community Engagement Project. This focussed upon patterns and levels of drug and solvent misuse amongst the youth and young people of the Greater Manchester Orthodox Jewish Community and was the catalyst for significant additional resources being diverted towards ethnically sensitive, teenage drug and solvent support activities within the community. Copying the format adopted previously The Project Team was charged with:

- Developing and understanding the issues.
- Undertaking the interviews with relevant professionals.
- Arranging and transcribing the focus groups.
- Contacting and collaborating with both mainstream service providers and voluntary organisations within the community working in the field of mental health support provision.
- Distributing and collecting of the project questionnaires.
- Computing and analysing data received and the preparation of graphs and tables.
- Assisting with the writing, compiling and editing of the final project report

To aid The Project Team a series of training workshops was provided by the Centre for Ethnicity and Health at The University of Central Lancashire. These were based around specialist workshops conducted on a range of relevant topic areas including:

- Issues concerning Mental Health.
- Patterns and categories of mental illness.
- Community Engagement techniques.

- Research methods and analysis.
- Report writing and presentation.
- Best practice and ethics.

The University also assisted the project by assigning it a support worker, Valerie Chawla. Throughout the project her professionalism her absolute dedication was unflagging and truly remarkable. Her professional expertise and input was essential in many different areas but primarily manifested itself in:

- Helping the team on points on a regular basis.
- Providing specialist knowledge around the issues.
- Acting as a link between The University and the project.
- Attending steering group meetings.
- Assisting in the report's compilation and writing.

Under the advice of the University a Project Steering Group was formed early on. Its composition was similar to that of Binoh's previous Community Engagement Project being comprised of members of The Project Team, and representatives from the Binoh Management Committee, local community mental health professionals and activists, the Centre for Ethnicity and Health at The University of Central Lancashire, Salford, Bolton and Trafford Mental Health Trust Patient Advice Liaison Service and The Pennine Care N.H.S. Trust (which covers mental health service provision within Bury). The latter two were included to fulfil the project's aim of requiring all groups to engage with relevant service providers and to involve strategic planning and commissioning bodies in its work. They were also regarded as vital to the project's goal of explaining the community's needs to mainstream service providers.

During the project's lifetime, at strategic crossroads within the project's delivery, the Steering Group convened to discuss strategic project planning and presentation. The dedication of the group despite their busy schedules and crowded timetables undoubtedly contributed to the project's success. A measure of the perceived success of the Steering Group was the decision recently taken by the Salford Orthodox Jewish Forum to agree to continue the work of the Steering Group once the project is completed and to establish within the framework of the forum a Community Working Party on Mental Health

As explained in the introduction, the project adopted a range of standard academic assessment methods to collect both qualitative and quantitative data via:

1) Questionnaires including both open and closed questions.
2) Discussions and interviews.
3) Focus Groups

Due to the sensitive nature of mental health especially within a tight knit ethnic minority community where arranged marriages are still the norm there were real concerns that respondents' fears of identification or discovery would hinder the project's success and effectiveness. To overcome this problem the questionnaire covering letter contained a confidentiality guarantee (printed in bold type and underlined) stating "We can absolutely assure you that all information will be treated with the utmost confidentiality; no names will be recorded and no identifying information will be passed on to anyone outside the research team. All information will be destroyed once the report has been compiled".

The use of anonymously distributed questionnaires was decided upon as being the most fruitful way of easily accessing the views of large numbers of people. During the formulating of the questionnaire, however, a major issue arose which at one stage threatened to jeopardise the entire project. One of the 'core' questions posed to respondents and required by The University concerned answering a question regarding matters of an individual's sexual orientation. Both The Project Steering Group and The Binoh Management Committee felt that the inclusion of such a question would run contrary to the community's firm religious guidelines concerning these issues. Furthermore Binoh occupies a near unique position within the community, being trusted by it yet having substantial links with outside statutory organisations. It was strongly felt that it could not abuse that trust by being seen to introduce questions that challenged the accepted ethical code existing within the community. . As one Project Team member pertinently explained at a meeting it is precisely because of the inclusion of such questions by mainstream service agencies to those wishing to access their services that so distresses and upsets ethnic minority communities and discourages them from accessing these services.

The problem of posing a question that would meet the needs of The University to collate core data of respondents without undermining Binoh's standing or compromising people's religious beliefs became exceptionally thorny and at one time it was feared that this could even threaten the entire project. After lengthy discussions a solution was found which satisfied all parties and a question was included at the end of the questionnaire reading "Are there any other issues of a sensitive or intimate nature in your lifestyle that you would like to include on this form?". The University's flexibility around this question was greatly acknowledged and appreciated by all those involved in the project.

The project questionnaires were rigorously analysed using standard data collection and computing procedures (primarily Microsoft Excel and Access programmes). After the initial entering of the data, results were checked and then tabulated and compiled (c.f. Results section). After this stage any unusual data or points of interest were discussed together by the project team prior to being confirmed and placed in the report. The object of this 'double firewall' system was, hopefully, to prevent any unreliable or 'rogue' data from entering the report and thereby jaundicing its conclusions, results or recommendations.

To guarantee credibility it was similarly decided that all one to one interviews and focus groups were to be subjected to similar rigorous analysis. After being unobtrusively taped and brief notes taken during the event itself they were all then thoroughly transcribed and written up shortly afterwards before being subject to peer analysis and scrutiny. It was agreed by The Project Team that this method had been very effective since the technical difficulties of taping large group events e.g. focus groups meant that often the quality of the recording received was relatively poor and reliance on this method alone would have been highly unsatisfactory.

RESULTS

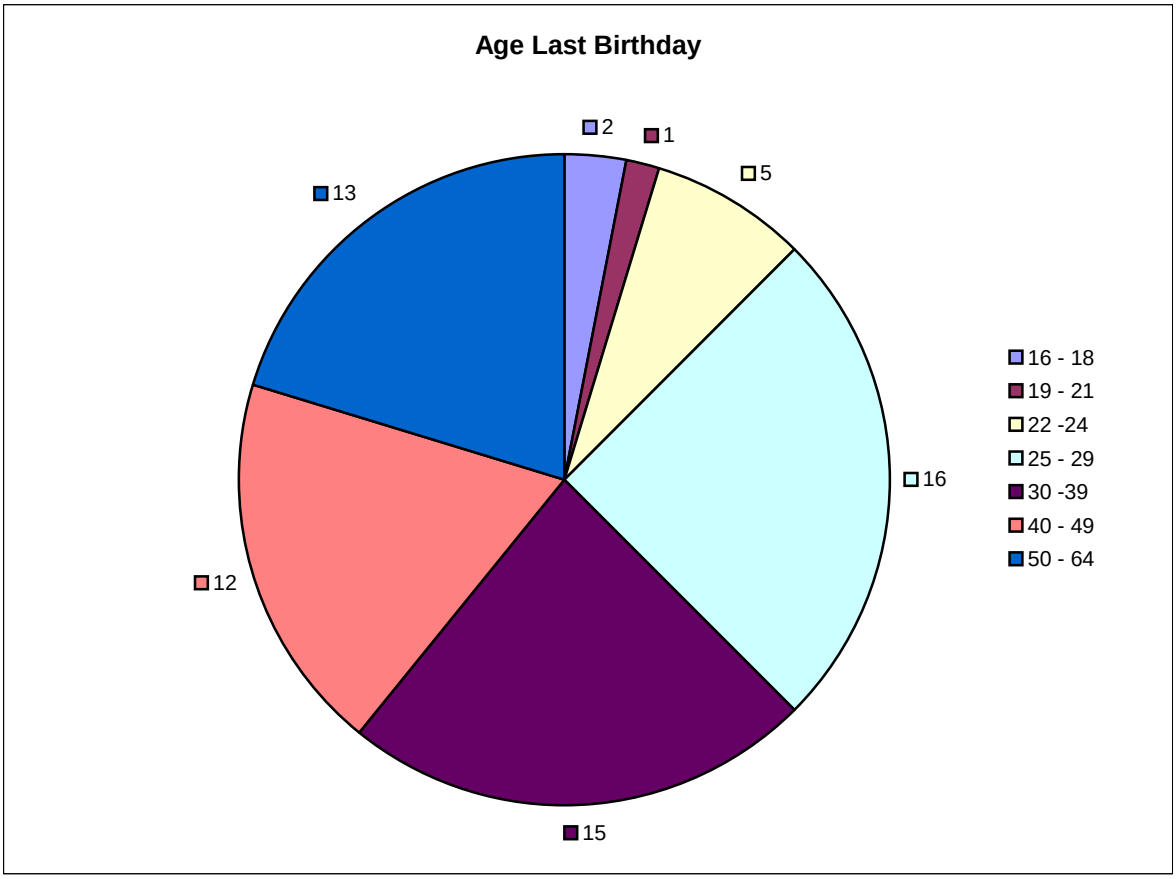
Detailed Questionnaire Analysis

The survey covered 64 respondents drawn from the North Manchester Orthodox Jewish Community.

SECTION A – BACKGROUND DATA

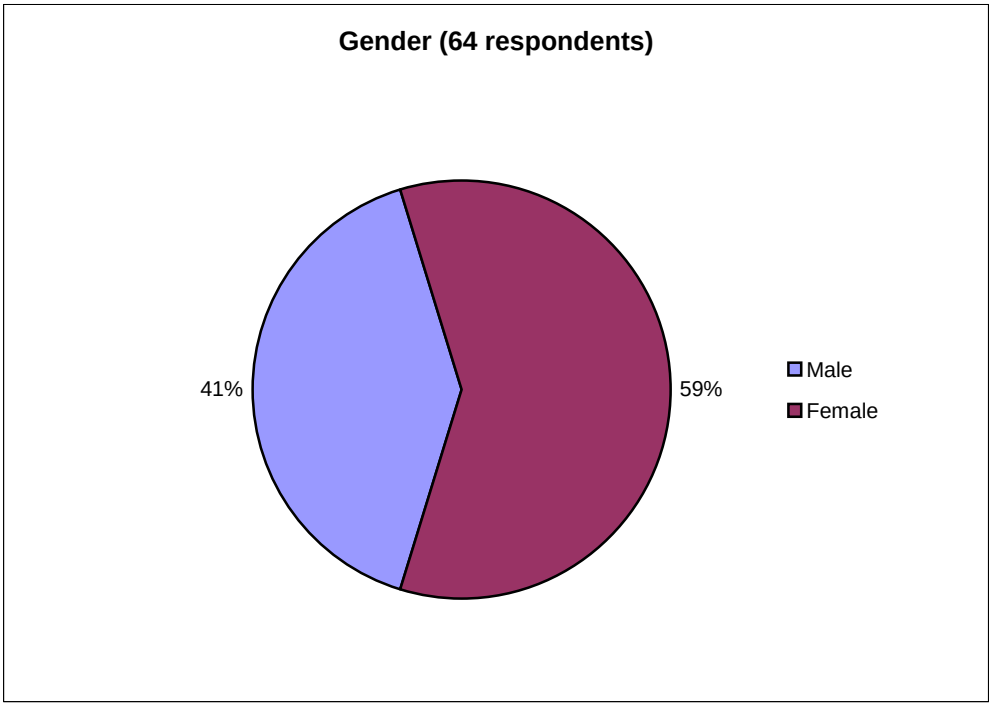
Question 1. Age Last Birthday

13 respondents were aged between 50-64, 12 between 40-49, 15 between 30-39,
16 between 25-29, 5 between 22-24, 2 between 16-18 and 1 aged between 19-21.



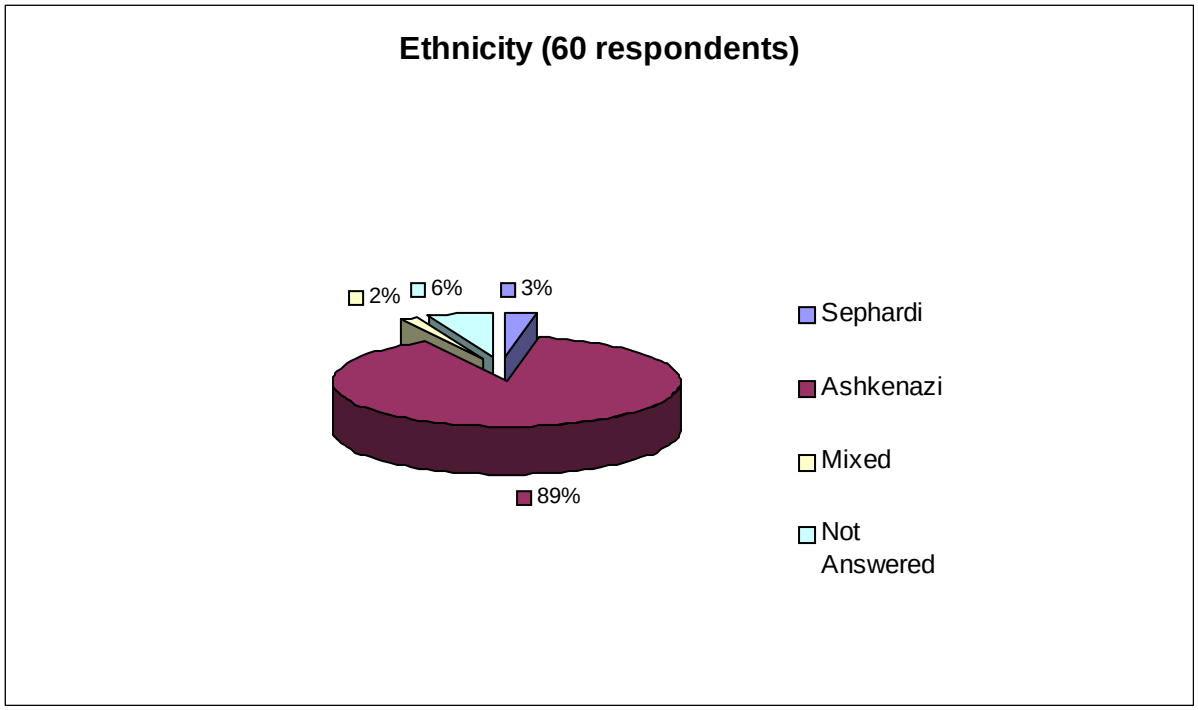
Question 2. Gender

59% of respondents (38) were female and 41% (26) were male.



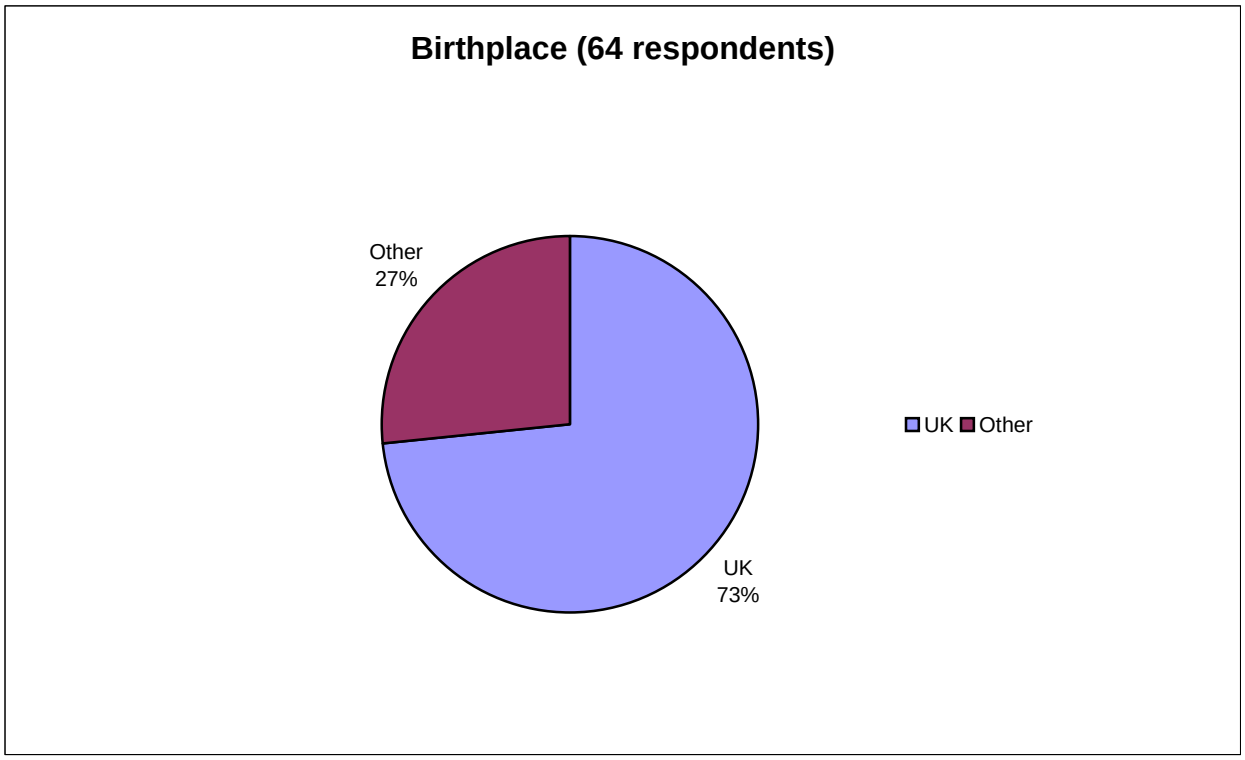
Question 3. Ethnicity

57 respondents were Ashkenazic, 2 respondents were Sephardic, 1 respondent described themselves as mixed Ashkenazic/Sephardic descent.


Ethnicity (60 respondents)
2%
6%
3%
89%
Sephardi
Ashkenazi
Mixed
Not Answered

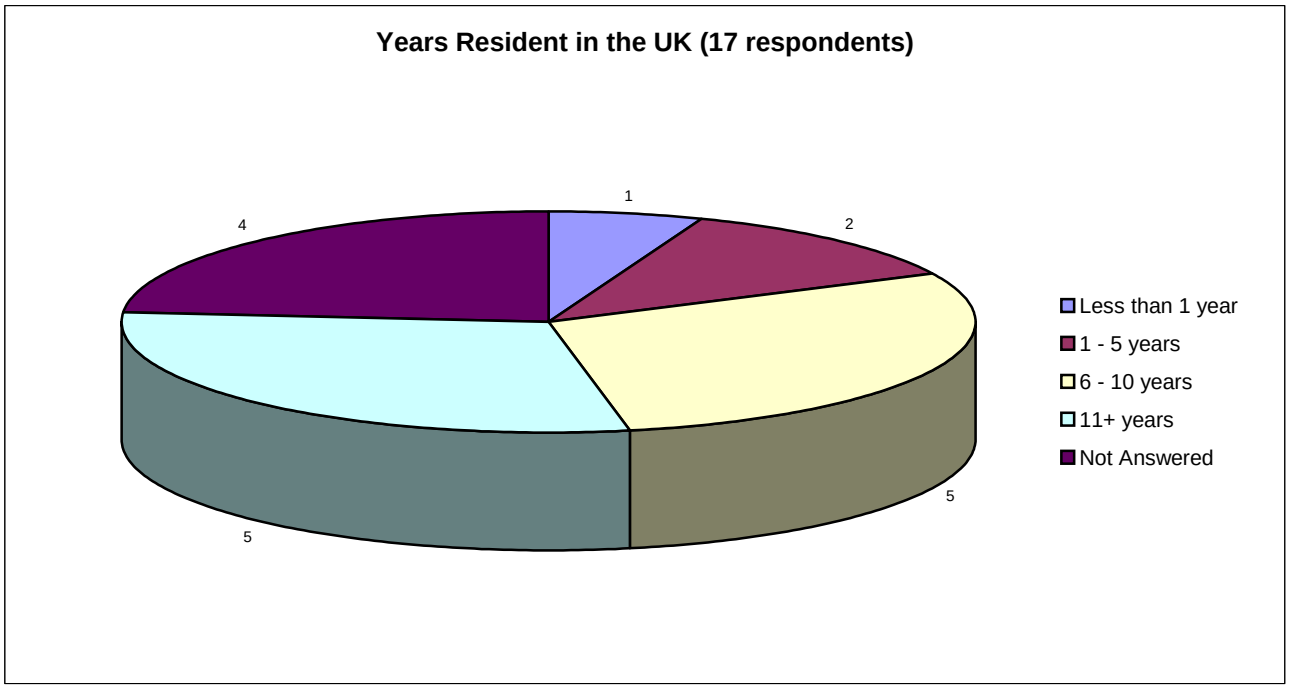
Question 4.1 Were You Born in the UK?

47 respondents were born in the UK, 17 respondents were born elsewhere.

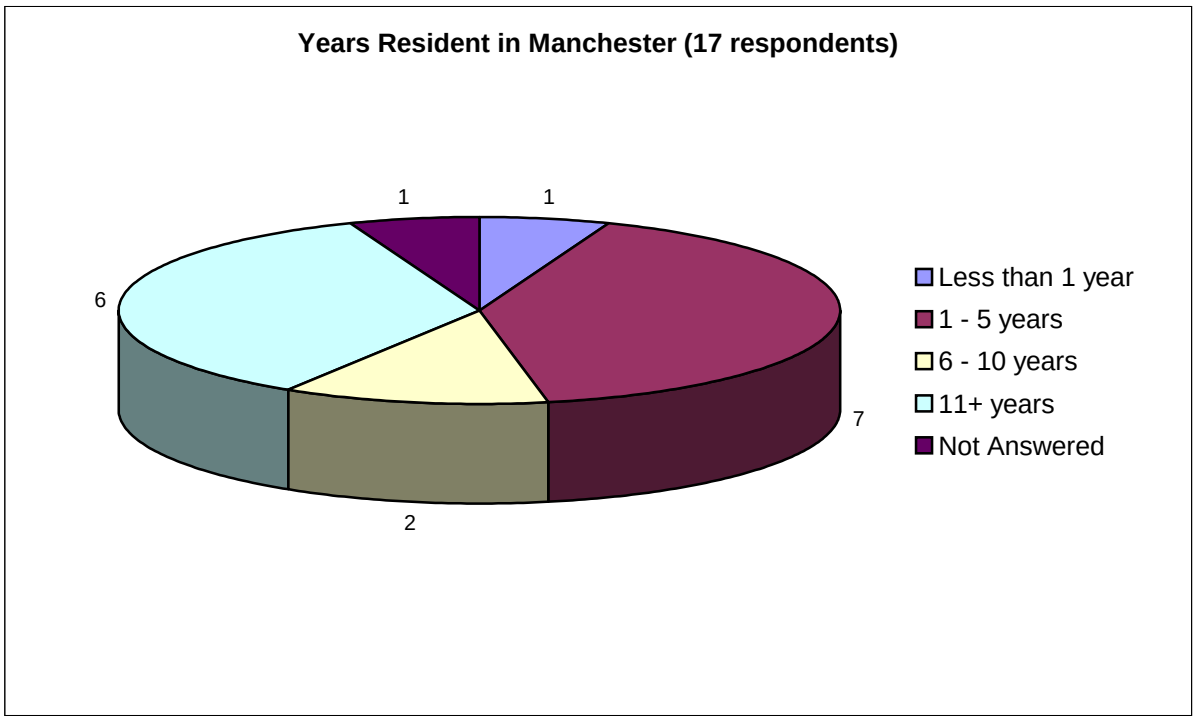


Question 4.2 Respondents not Born in the UK – Years Resident in the UK

17 respondents were born outside of the UK

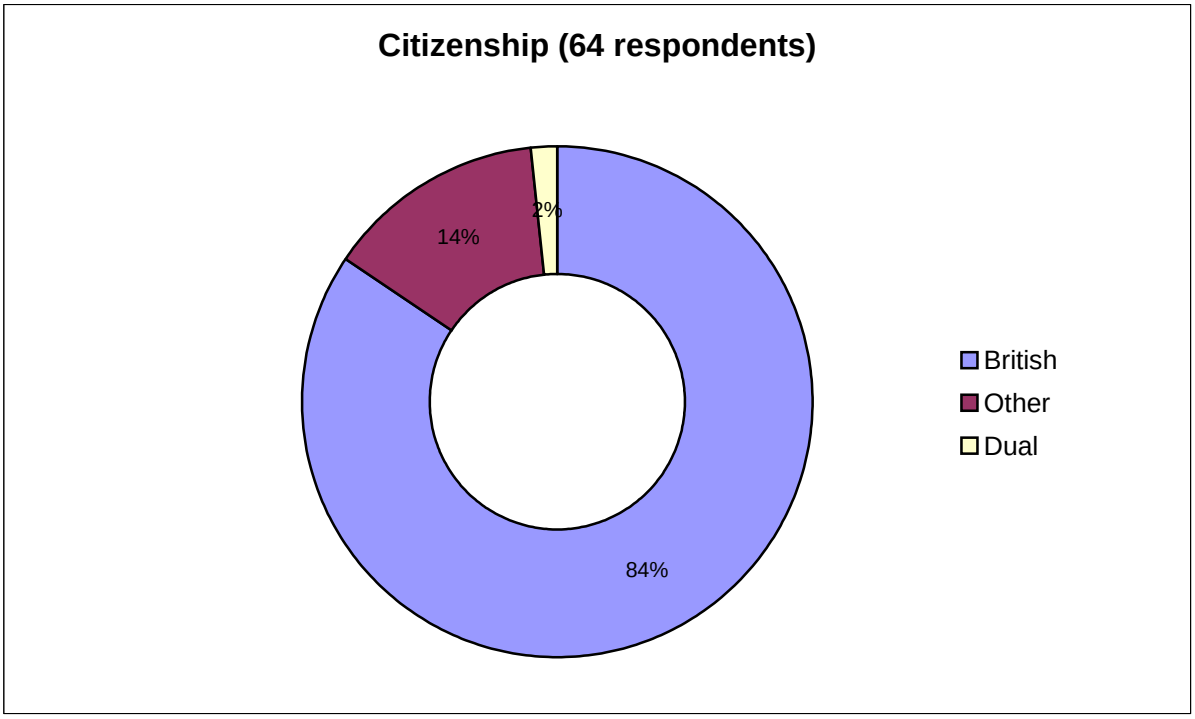


Question 4.3 Respondents not Born in the UK – Years Resident in Manchester



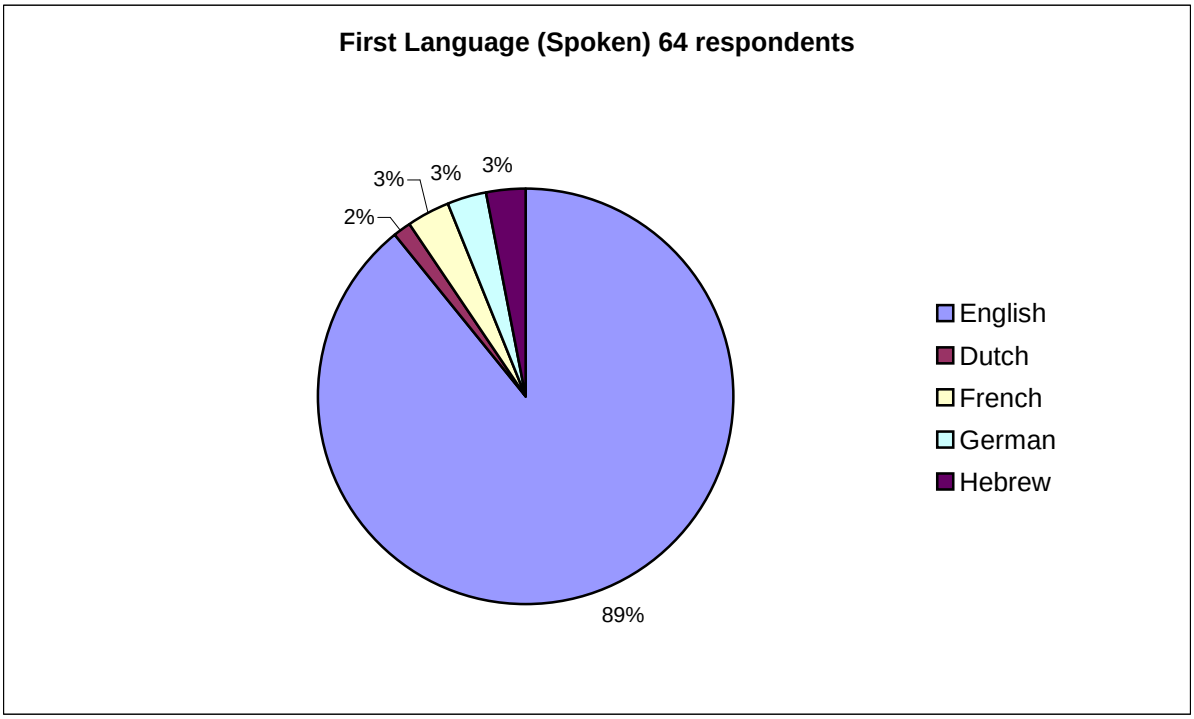
Question 5. Citizenship

54 respondents were UK Nationals, 9 respondents were non-UK Nationals, 1 respondent had dual British/Other nationality.



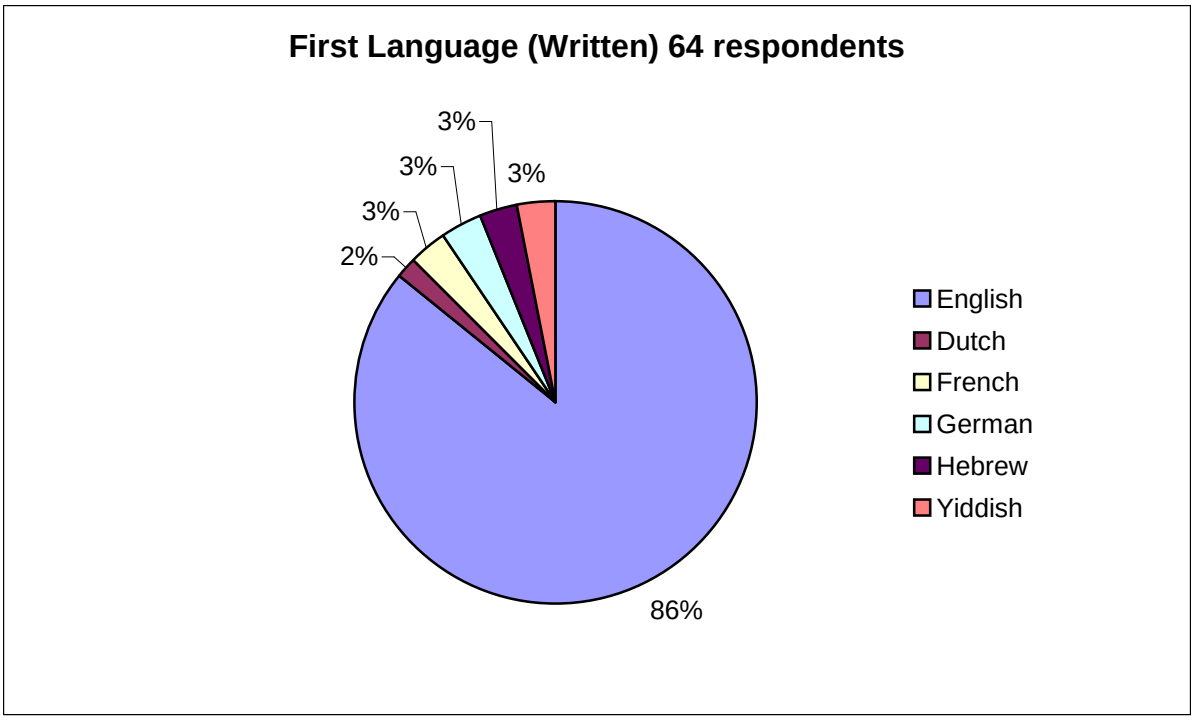
Question 6.1 First Language (Spoken)

57 respondents stated English as their first spoken language, 1 respondent Dutch,
2 respondents French, 2 respondents German, and 2 Hebrew (modern).



Question 6.2 First Language (Written)

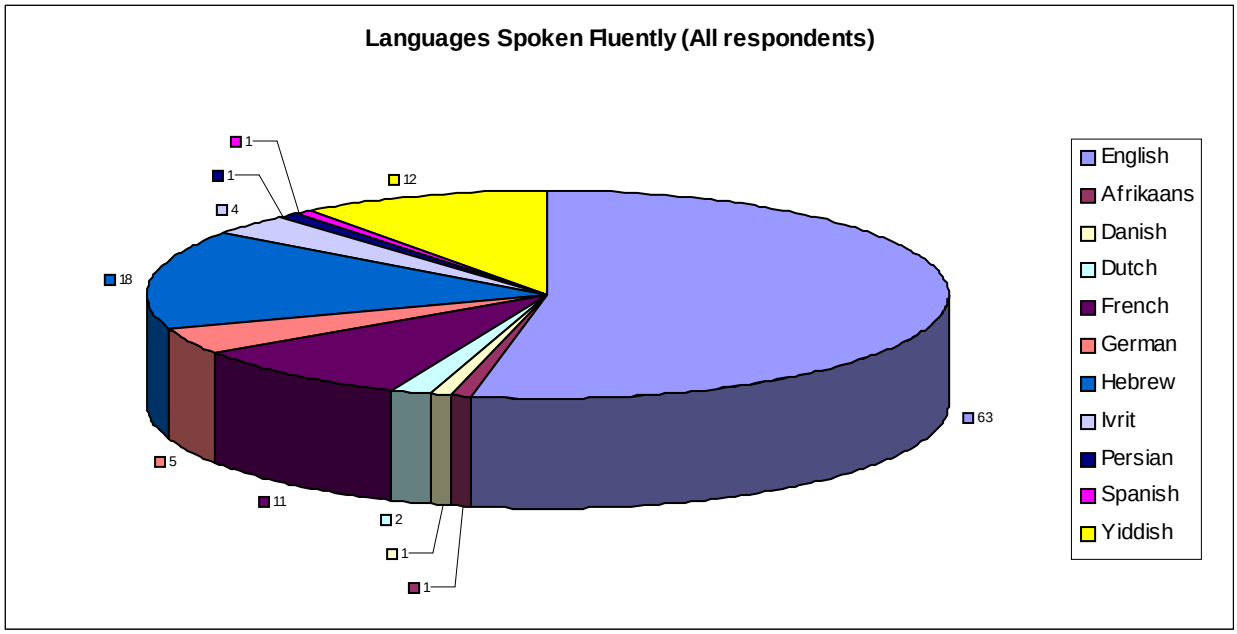
55 respondents stated English as their first spoken language, 1 respondent Dutch,
2 respondents French, 2 respondents German, 2 Hebrew and 2 Yiddish.



Question 6.3 Languages Spoken Fluently

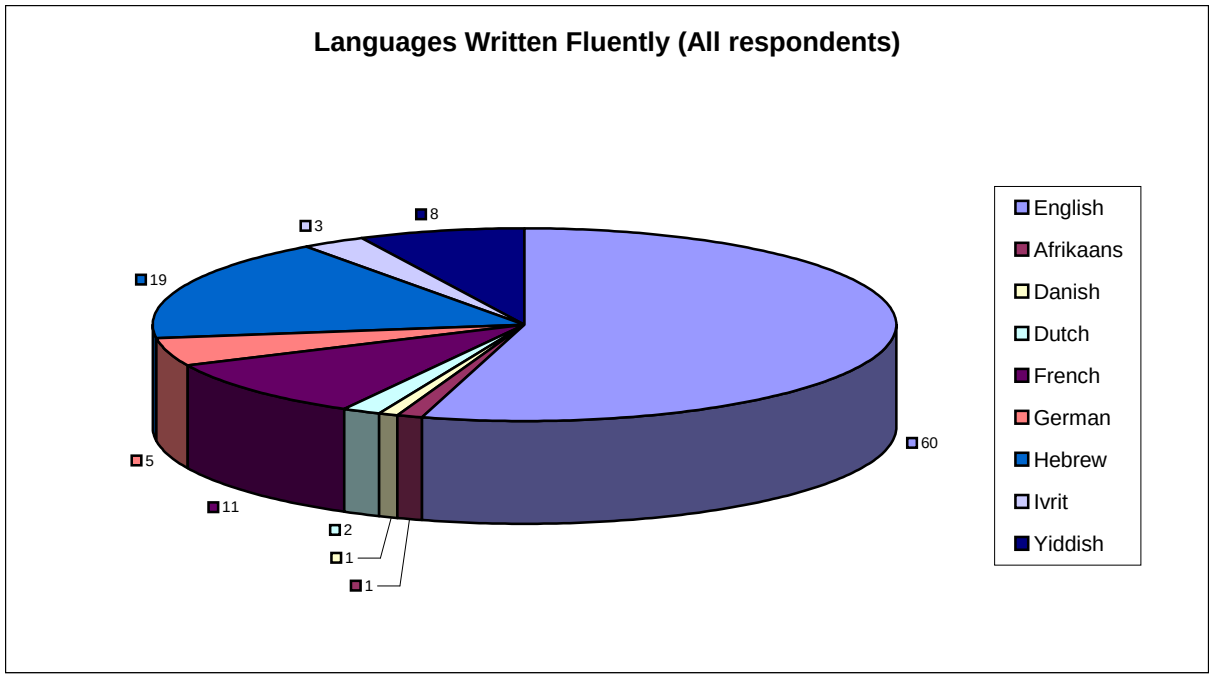
63 respondents stated that they were fluent English speakers.
18 respondents stated that they were fluent in Hebrew and 4 in Ivrit (Modern Hebrew). Hebrew and Ivrit can usually be taken as being synonymous in this context.

12 respondents stated that they were fluent in Yiddish, 11 in French, 5 in German,
2 in Dutch, 1 in Afrikaans, 1 in Danish, 1 in Persian, 1 in Spanish.



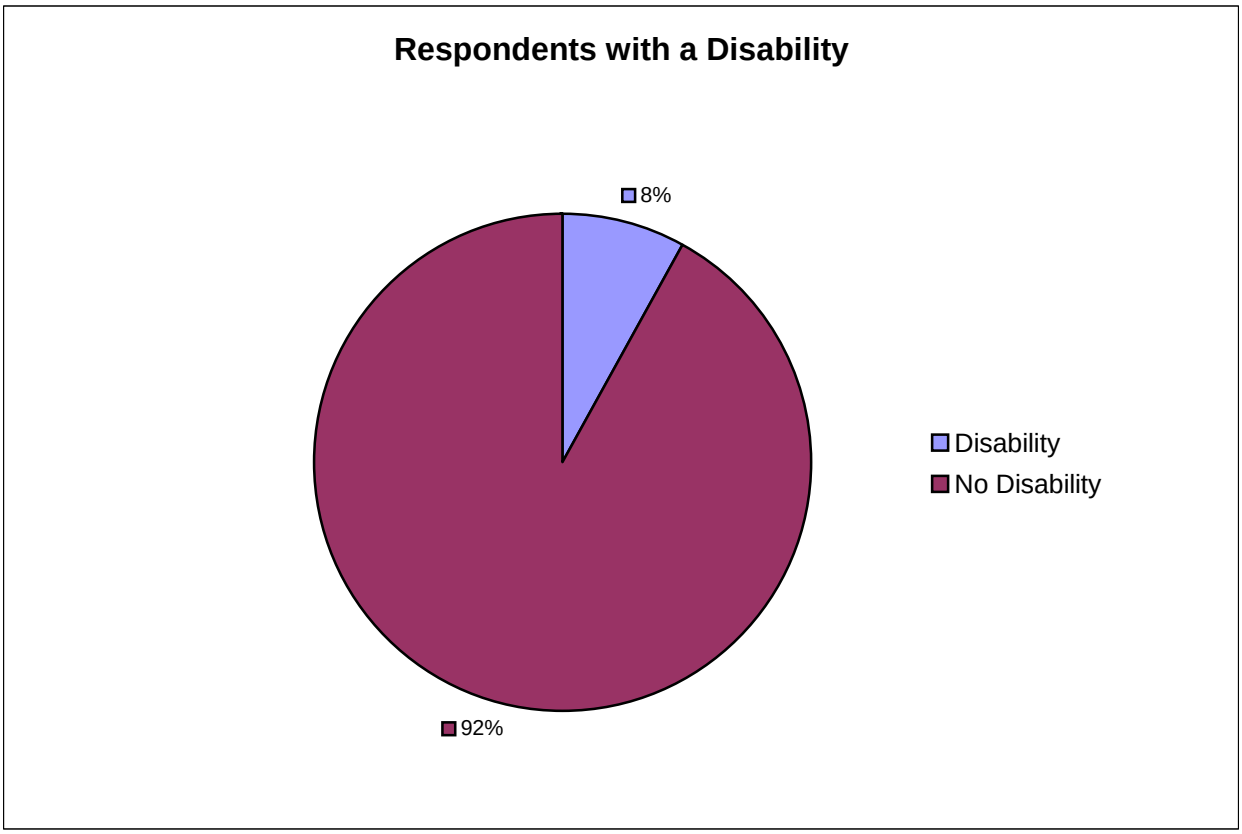
Question 6.4 Languages Written Fluently

60 respondents stated that are able to write English fluently.
19 respondents stated Hebrew and 3 stated Ivrit (Modern Hebrew). Hebrew and Ivrit can usually be taken as being synonymous in this context.
11 French, 8 Yiddish, 5 German, 2 Dutch, 1 Afrikaans, 1 Danish, 1 in Spanish.



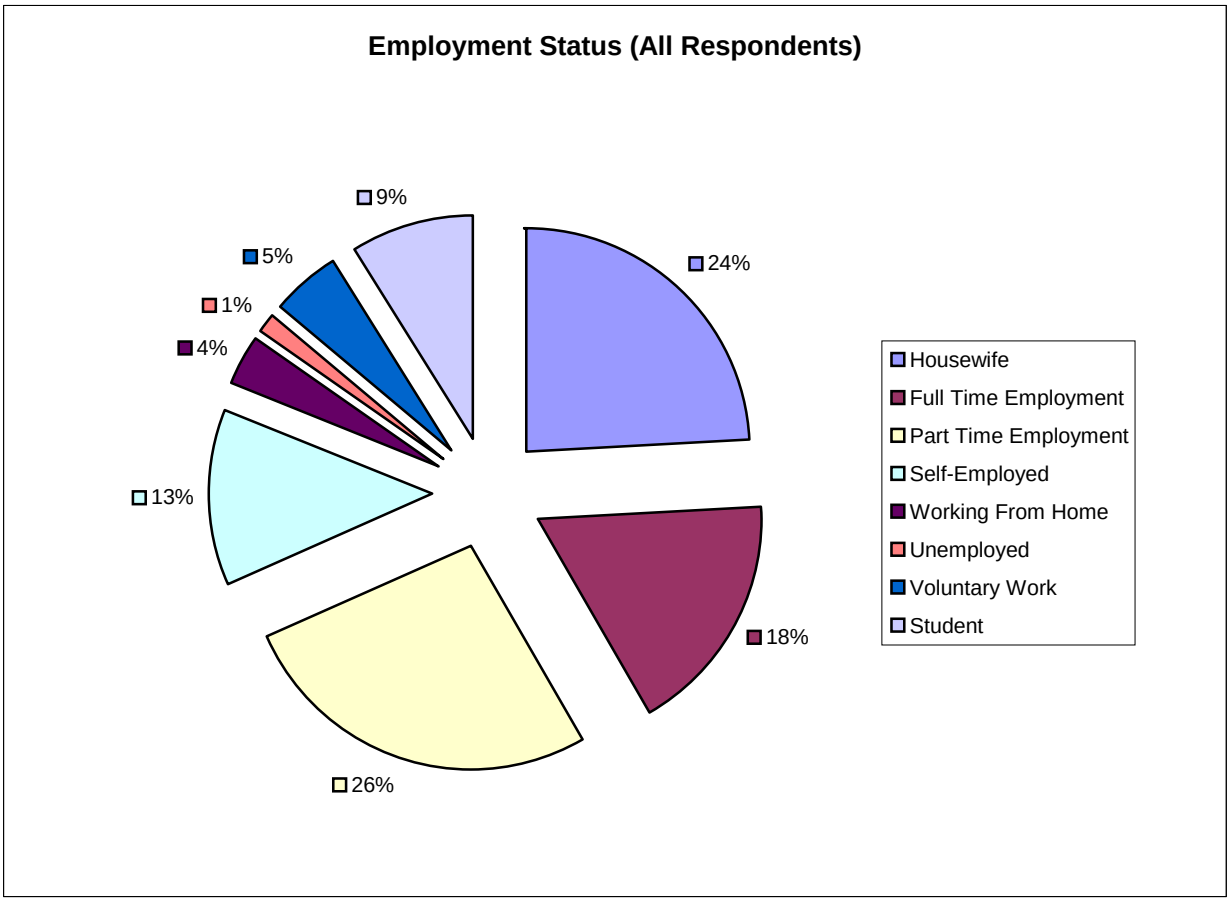
Question 7. Do You Have a Disability?

Only 5 out of the 64 respondents reported that they have some form of disability.



1 respondent stated that they had a speech defect
1 respondent stated that Dyslexia/ADHD
1 respondent reported Tendernitis
2 respondents did not elaborate on the nature of their disability

Question 8. Employment Status



A number of respondents reported multiple employment status e.g. Self employed and Working from Home. A number of female respondents describing themselves as Housewives also responded that they were in Part Time employment or undertook Voluntary Work.

The breakdown was as follows;

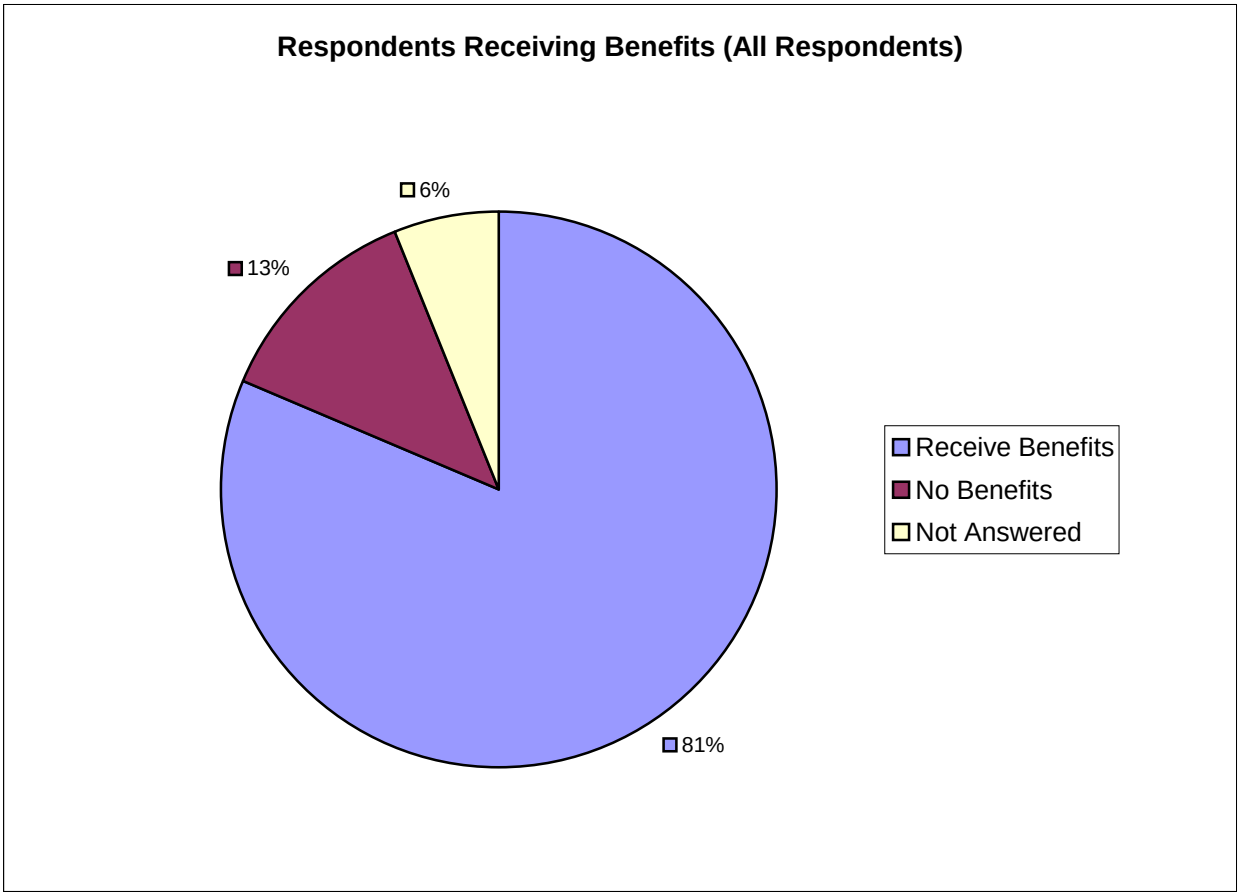
Number of respondents 64.

Category	Number of Responses
Housewife	19
Full Time Employment	14
Part time Employment	21
Self Employed	10
Working From Home	3
Unemployed	1
Voluntary Work	4
Student	7
Total	79

Question 9. Respondents Receiving Benefits

52 respondents (81% of all respondents) received one or more benefits.

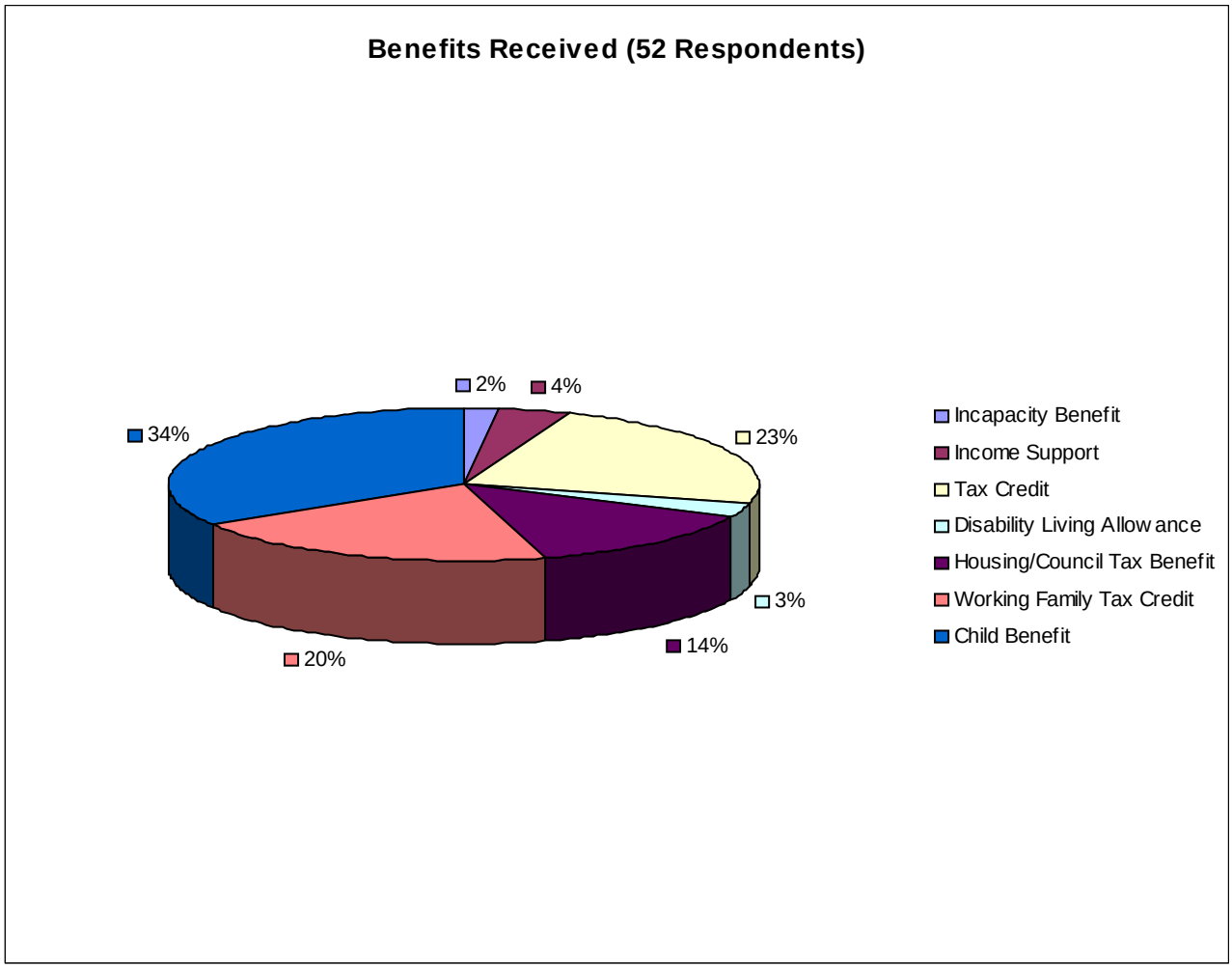
8 respondents received no benefits and 4 respondents did not answer the question.



A large number of the 52 respondents reported that they receive several benefit entitlements.

A large proportion of the 52 respondents reported that they received Child Benefit, Working Family Tax Credit and Housing/ Council Tax Benefit.

Question 9.1 Range of Benefits Received



The breakdown was as follows;

Number of respondents 52.

Category	Number of Responses
Child Benefit	35
Working Family Tax Credit	21
Housing/Council Tax Benefit	14
Tax Credit	24
Income Support	4
Disability Living Allowance	3
Incapacity Benefit	2
Total	103

SECTION B – UNDERSTANDING OF MENTAL HEALTH AND MENTAL HEALTH ISSUES

Question 10. What does Mental Health mean to you?

The following italicised paragraphs are definitions of mental health taken from a number of sources and can perhaps serve as a base against which to evaluate the responses from interviewees to this question.

Mental health is a term used to describe either a level of cognitive or emotional wellbeing or an absence of mental illness. From perspectives of the discipline of positive psychology or holism mental health may include an individual's ability to enjoy life, procure a balance between life activities, and efforts to achieve psychological resilience. (Source: Wikipedia)

The World Health Organization states that there is no one "official" definition of mental health. Cultural differences, subjective assessments, and competing professional theories all affect how "mental health" is defined. . (Source: Wikipedia)

Mental health: the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people and the ability to adapt to change and cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communications skills, learning, emotional growth, resilience and self-esteem. (Source: Fountain house Program)

Mental health: How a person thinks, feels, and acts when faced with life's situations. Mental health is how people look at themselves, their lives, and the other people in their lives; evaluate their challenges and problems; and explore choices. This includes handling stress, relating to other people, and making decisions. (Source: Dorene J. Philpot – US Attorney at Law –Special Education Law)

Mental illness: the term that refers collectively to all mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood or behavior (or some combination thereof) associated with distress and/or impaired functioning. (Source: Fountain house Program)

Of the 64 respondents interviewed 21 did not answer this question.

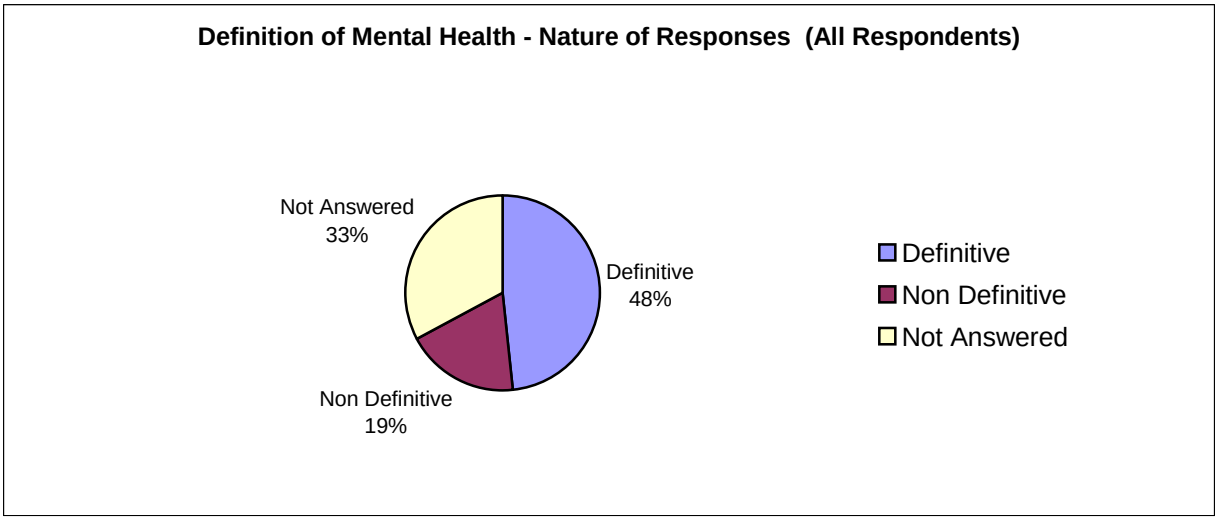
The answer from a further 12 respondents was not particularly definitive. This could be interpreted as either an inability on the behalf of those respondents to articulate their understanding of mental health or be viewed as demonstrating a vague understanding of mental health issues in general. Their responses were;

1) A very lot.
2) An illness.
3) Coping with all of life.
4) Extremely important.
5) Mental Illness
6) Mental problems.
7) Most important.
8) Not being ill.
9) Priority/ must be recognised and accepted.
10) The state of a person's mental health.
11) To be balanced in one's way of life.
12) To be happy and healthy.

The remaining 31 responses did appear to be attempts at a definition;

1) A condition in the mind rather than with physical symptoms.
2) A mental condition where you feel you are in control of yourself and your immediate environment.
3) Ability to cope with demands of daily life in a socially acceptable & competent fashion.
4) An inability to function as a normal member of society due to non-physical problems shows a mental health problem.
5) Anorexia, Depression, Anxiety, Bulimia, Hypochondriac, Amnesia, Alzheimer's, Stress disorder.
6) Anyone who suffers either mentally disabled, or even someone who suffers emotionally, fears and panics.
7) Attention/care for a person's mental well-being.
8) Basically any illness that is not a physical illness.
9) Being able to cope with the various trials & tribulations that may come one's way.
10) Being stable mentally.
11) Being unable to cope on a regular basis with some or all aspects of daily living.
12) Emotional well-being, having a good & healthy frame of mind and outlook, so I can cope with everyday challenges.
13) Feel happy coping positively in every situation, Balanced personality.
14) Feeling happy, able to cope in positive and negative situation and balanced personality.
15) Health of the mind, emotions, mental well being.
16) Health of the mind.
17) Healthy functioning of the mind and emotions.
18) How emotionally stable one is. Is one's reactions in the parameters of average/reasonable?
19) I think it's important and everyone should be entitled to any help that can be provided for them.
20) It means to me that people do not act/speak in the normal manner. They do not have the intelligence of well people.
21) Peace of mind, happier family environment.
22) Person suffering emotionally, family also suffer embarrassment.

23) Positive feeling of well-being.
24) Someone who is not able to think and behave as is normally accepted.
25) Someone who is unstable and can't take care of himself emotionally.
26) Stable healthy way of life.
27) The ability to cope with every day life in a healthy way, Balance
28) The improvement of one's ability to cope day to day.
29) To be happy and feel fulfilled in ones role in life.
30) To be mentally healthy in order to deal with normal and stressful situations in life. - To feel good about
31) oneself and happy with life.
32) When emotional state doesn't impact on life style.

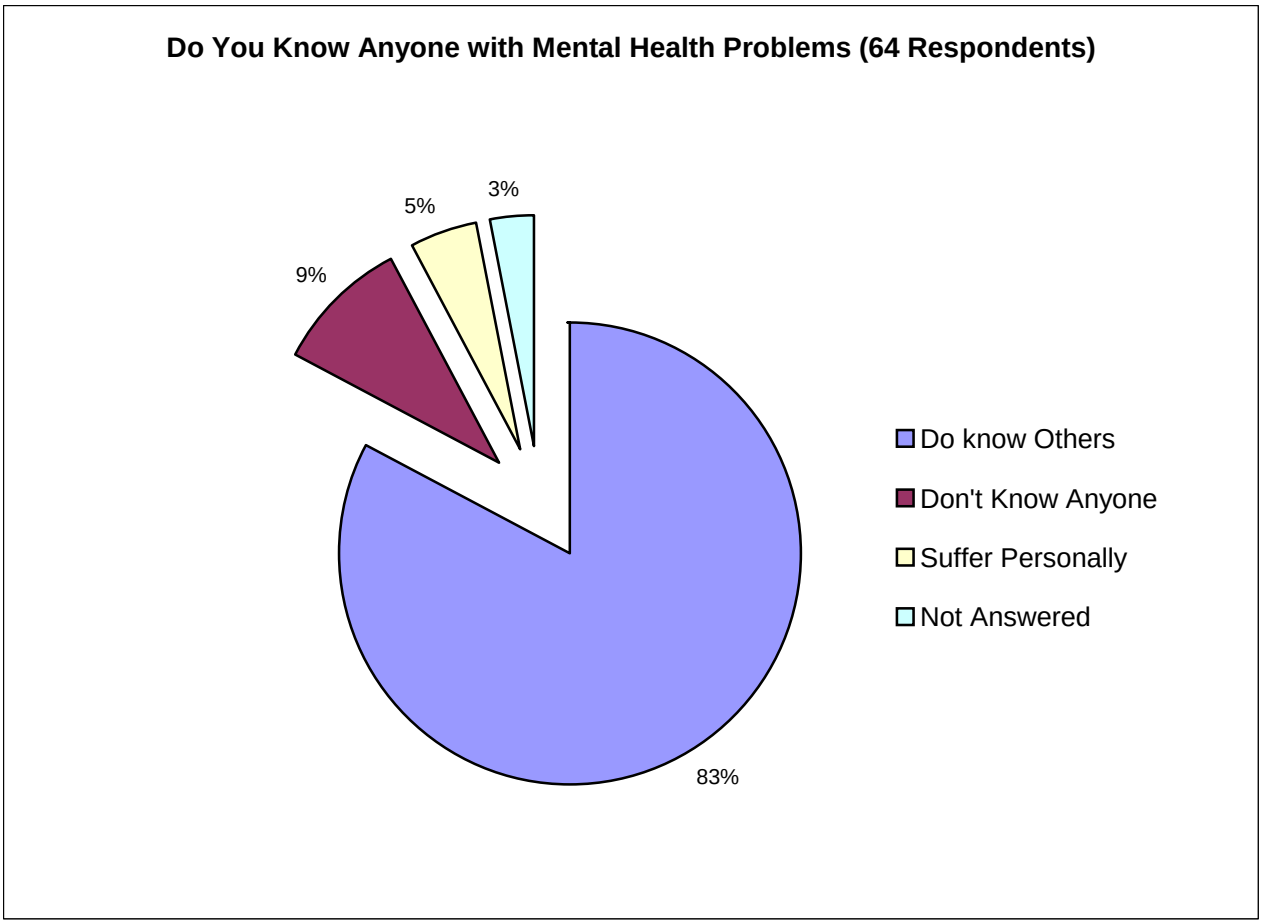


Question 11. Do You Know Anyone with Mental Health Problems?

56 respondents stated that knew of one or more people with mental health problems.

3 of these 56 respondents reported that also personally suffered with mental health problems

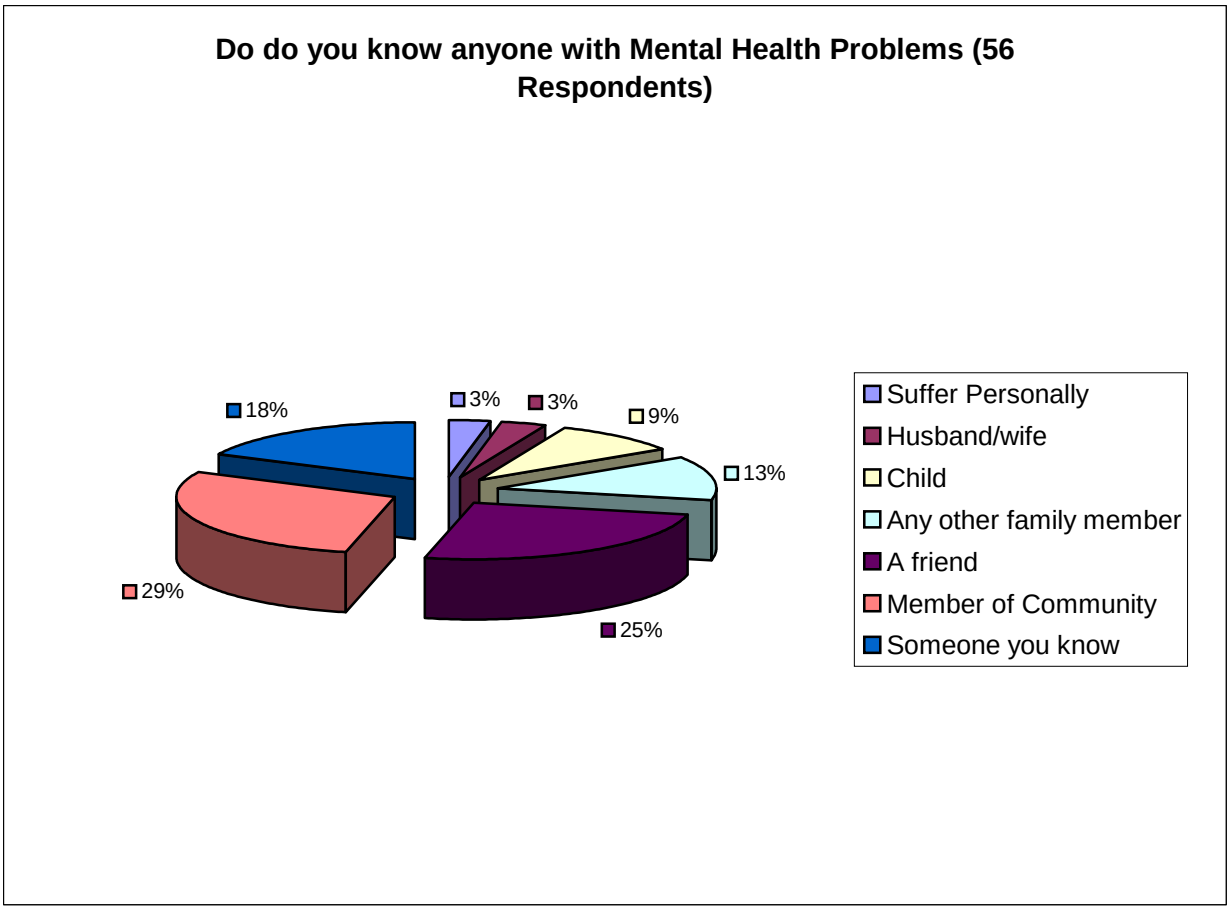
6 respondents said that they did not know anyone with mental health problems and 2 respondents did not answer the question.



The breakdown was as follows;

Number of respondents 56.

	Number of Responses
Suffer Personally	3
Husband/Wife	3
Child	9
Any Other Family Member	12
Someone You Know	17
Friend	24
Member of the Community	27
Total	95



Question 12. Do You Know Anyone Suffering from these Illnesses?

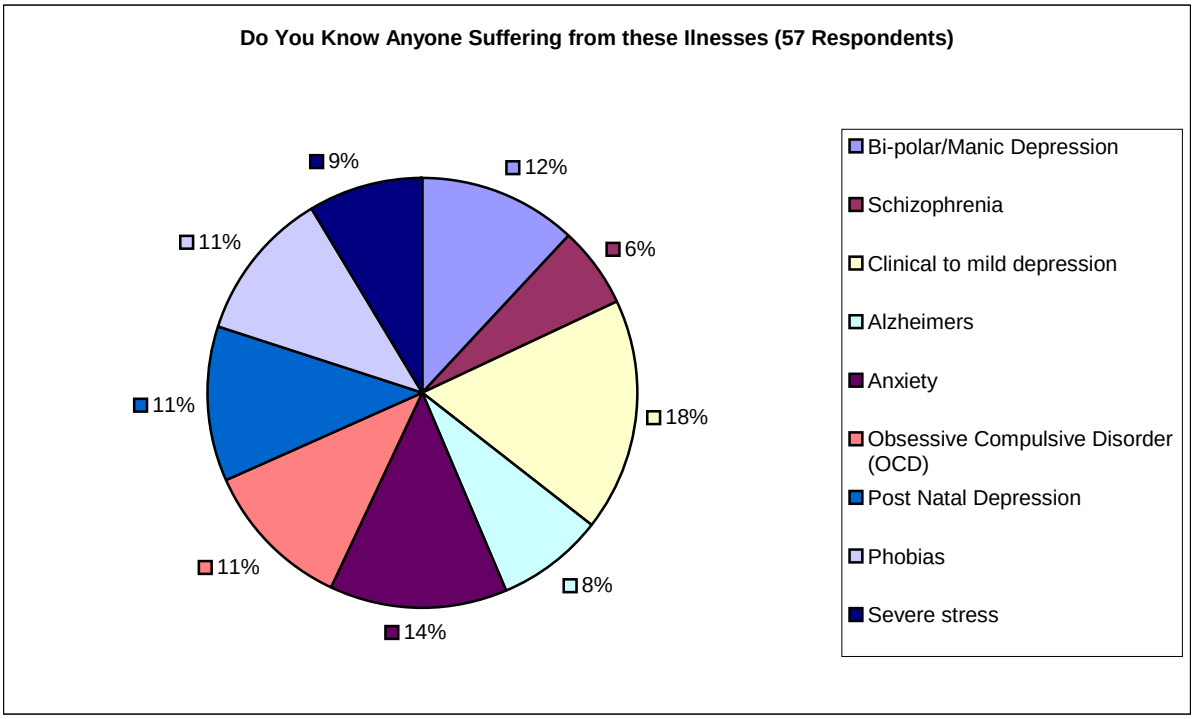
Bi-polar disorder/Manic depression

Schizophrenia
Clinical to mild depression
Alzheimer's
Anxiety
Obsessive Compulsive Disorder (OCD)
Post Natal Depression
Phobias (i.e. claustrophobia, agoraphobia, irrational fears, fear of heights etc.)
Severe stress (e.g. caused by financial worries, marriage difficulties etc.)

5 respondents said that they did not know anyone suffering from these illnesses.
2 respondents did not answer the question.
57 respondents reported that they knew a number of people suffering from one or more of these illnesses.

The breakdown was as follows;
Number of respondents 57.

Category	Number of Responses
Clinical to mild depression	26
Anxiety	20
Bi-polar disorder/Manic depression	18
Obsessive Compulsive Disorder (OCD)	17
Post Natal Depression	17
Phobias	17
Severe Stress	13
Alzheimer's	12
Schizophrenia	09
Total	149



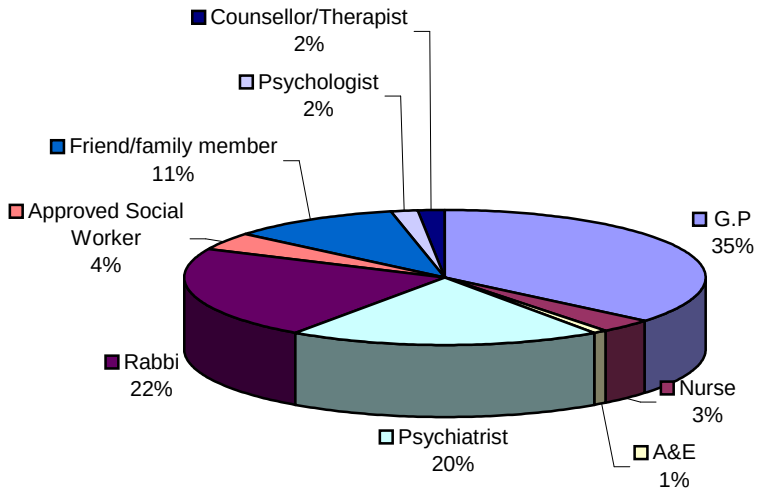
Question 13. Who would you go to for Help with a Mental Health Problem?

One respondent was unable to answer this question. All other 63 respondents suggested at least one and most more than one type of person/professional from whom they would seek advice and help.

These were as follows. 63 respondents.

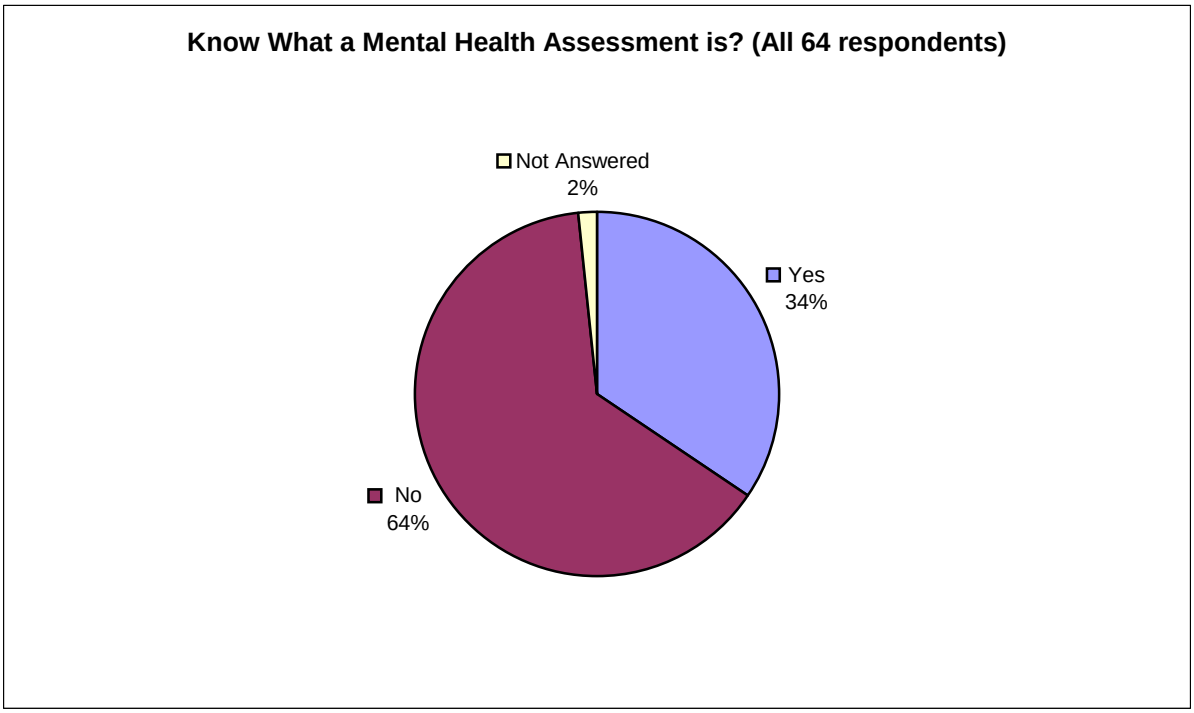
	Number of Responses
G.P.	44
Rabbi	27
Psychiatrist	24
Approved Social Worker	5
Friend/Family Member	13
Nurse	4
Counsellor/Therapist	2
Psychologist	2
A&E	1
Total	122

Who would you see for Help with a Mental Health Problem?
(63 Respondents)



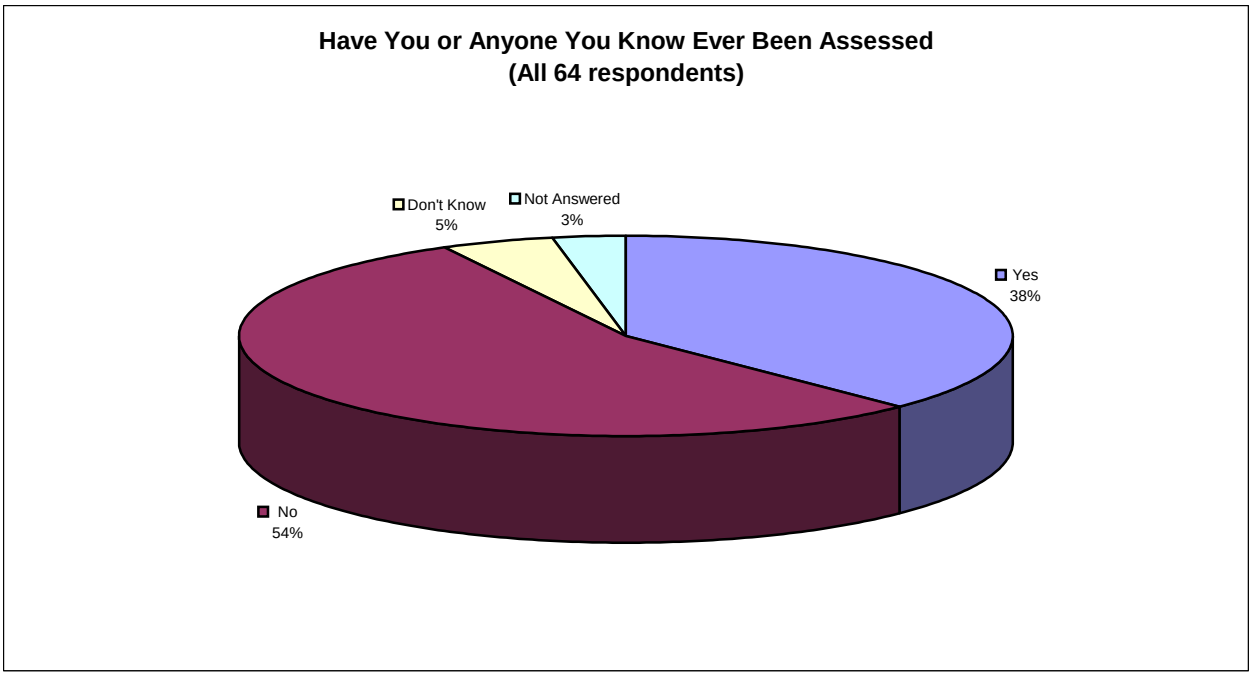
Question 14. Do you Know What a Mental Health Assessment is?

22 respondents claimed that they knew what a Mental Health Assessment is.
41 respondents reported that they did not know.
1 respondent did not answer this question.



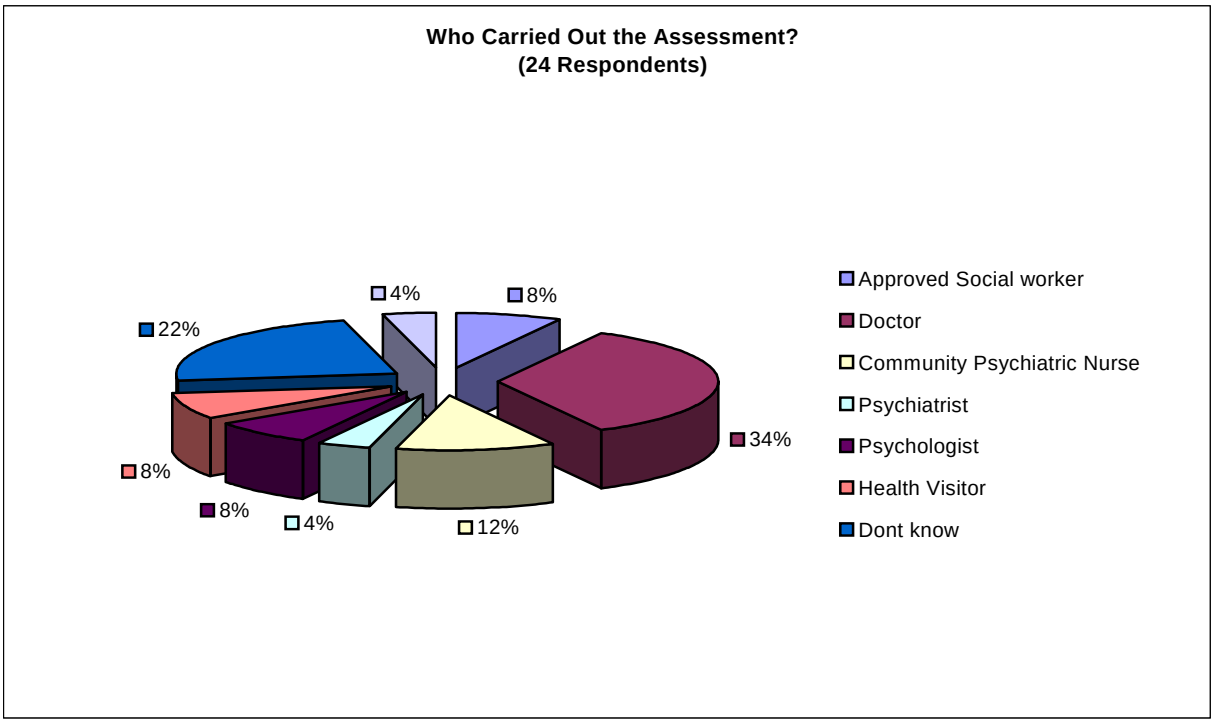
Question 15a. Have you or anyone you know ever been Assessed?

24 respondents answered yes to this question.
25 respondents answered no.
3 respondents reported that they didn't know
2 respondents did not answer the question.



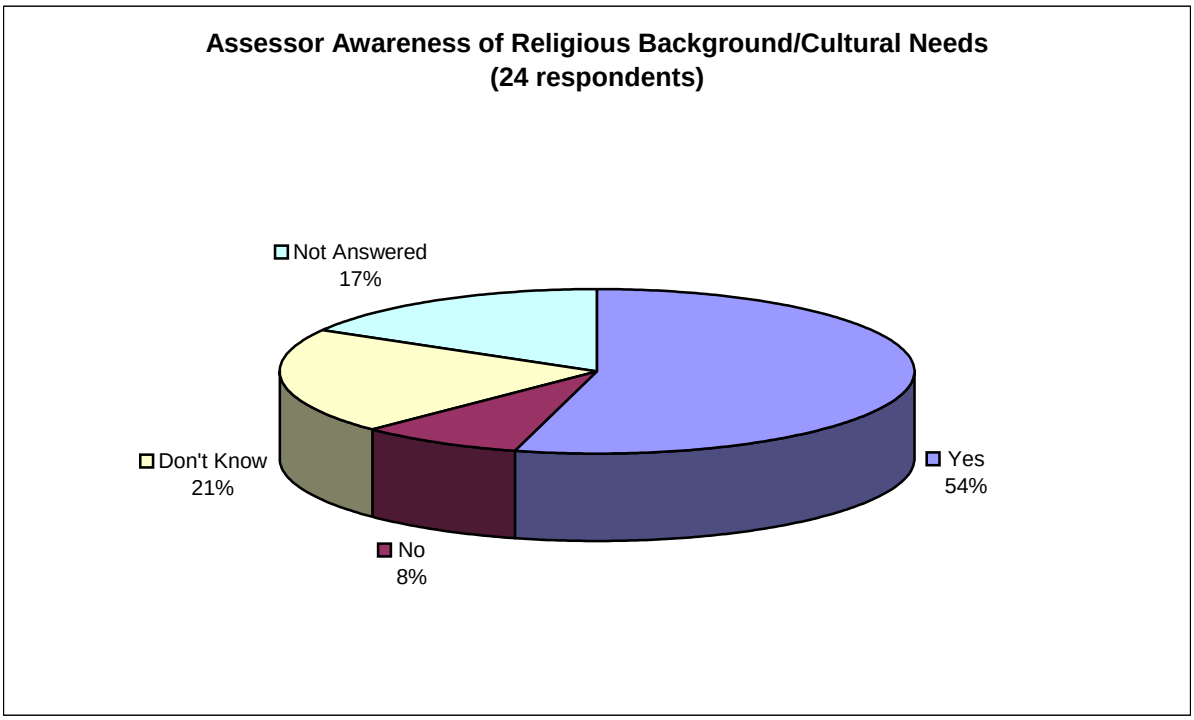
Question 15b. Who Carried Out the Assessment

One respondent cited Approved Social Worker, Doctor and Community Psychiatric Nurse. It is unclear whether or not the respondent was referring to three different cases.



Question 15c. Was Assessor aware of Religious Background/Cultural Needs?

13 respondents answered yes to this question.
2 respondents answered no to this question.
5 respondents were unable to give a definitive answer.
4 respondents did not answer this question at all.



Question 15c.1 If Yes – Please Explain

Comments where the assessor appeared to be aware of the religious background/cultural needs of the person under examination included;

1) The person was a member of the orthodox community himself.
2) Yes, But not always sympathetic.
3) Jewish Doctor.
4) The Doctor was Jewish
5) In a clinic, residential & kosher food was requested, and holocaust background discussed as a possible cause for the current problems.

6) Works in the community.
7) Jewish Orthodox Doctor.
8) She knew the person was Jewish
9) Knowledge of orthodox Jewish background.
10) Obviously yes in order to help them in the most beneficial way.
11) Was a Jewish psychologist.

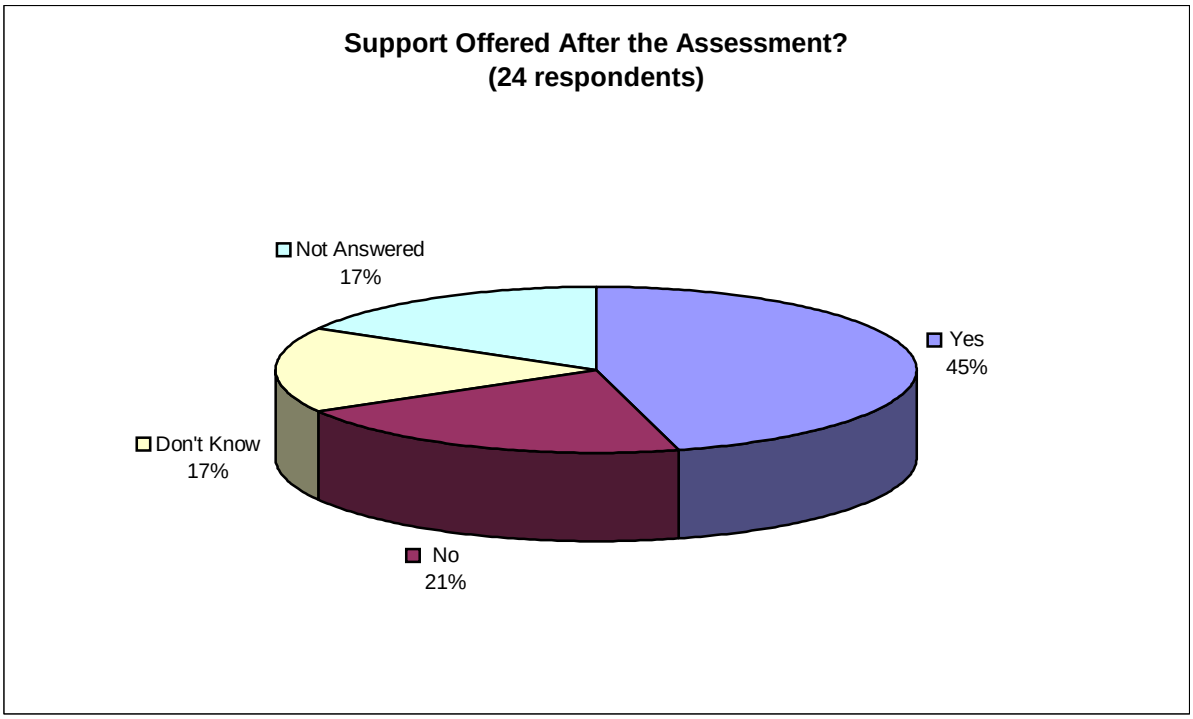
Question 15c.2 If No – Please Explain

There was only one comment offered where the assessor did not appear to be aware of the religious background/cultural needs of the person under examination.

1) Not culturally sensitive at all.

Question16. Was Any Support Offered After the Assessment?

11 respondents reported that support was offered. 5 respondents reported that no support was offered. 4 respondents did not know if any support was offered
4 respondents did not answer the question.



Question 17. What Help was offered?

Only 9 out of the 24 respondents who reported that they know someone who has been assessed answered this question.

Treatments/therapies cited were;

Treatment/Therapy	No. Of Instances Offered
Cognitive behavioural therapy	2
Group therapy	1
One to one counselling/Psychotherapy	4
Hospitalisation	1
Medication	1
Self-Help Books	1
	10

Question 18.1 Have They Received Alternative Therapies?

Only 5 respondents said that the patients they knew had received alternative therapies, 2 respondents that the patients they knew had not received alternative therapies, 3 respondents stated that they didn't know, 14 respondents did not answer the question.

Treatments/therapies cited were;

Treatment/Therapy	No. Of Instances Offered
Complementary medicines (i.e.. homeopathic remedies)	4
Acupuncture	3
Nutritional Advice	1
Massage inc. reflexology.	1
	9

Some patients were offered more than one type of therapy.

Question 18.2 If helpful please state why.

Answers were as follows;

1) Old person got lots of attention, which is part of what she seeks.
2) Acupuncture, it worked to calm her down.
3) Herbal. Did the trick.

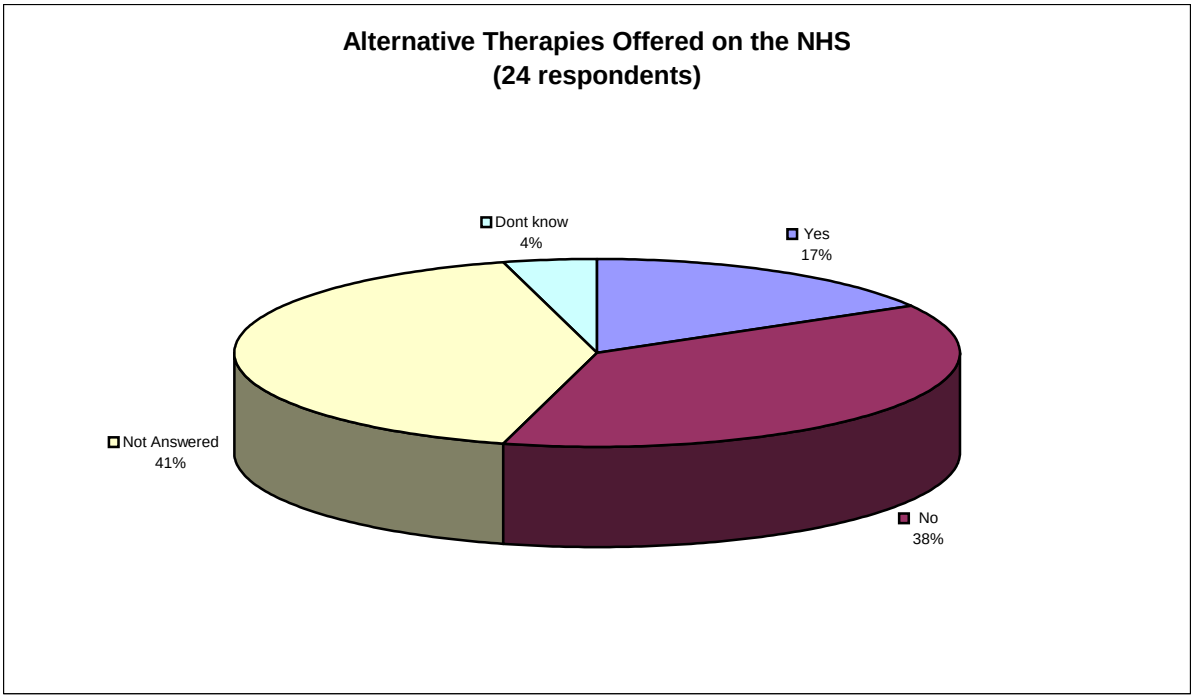
Question 18.2 If not helpful please state why.

Answers were as follows;

1) Waste of time-mostly depends on patient's own belief.
2) *Doesn't help cause of the problem*
3) Homeopathic for anxiety, she didn't believe in it.
4) Did not help.

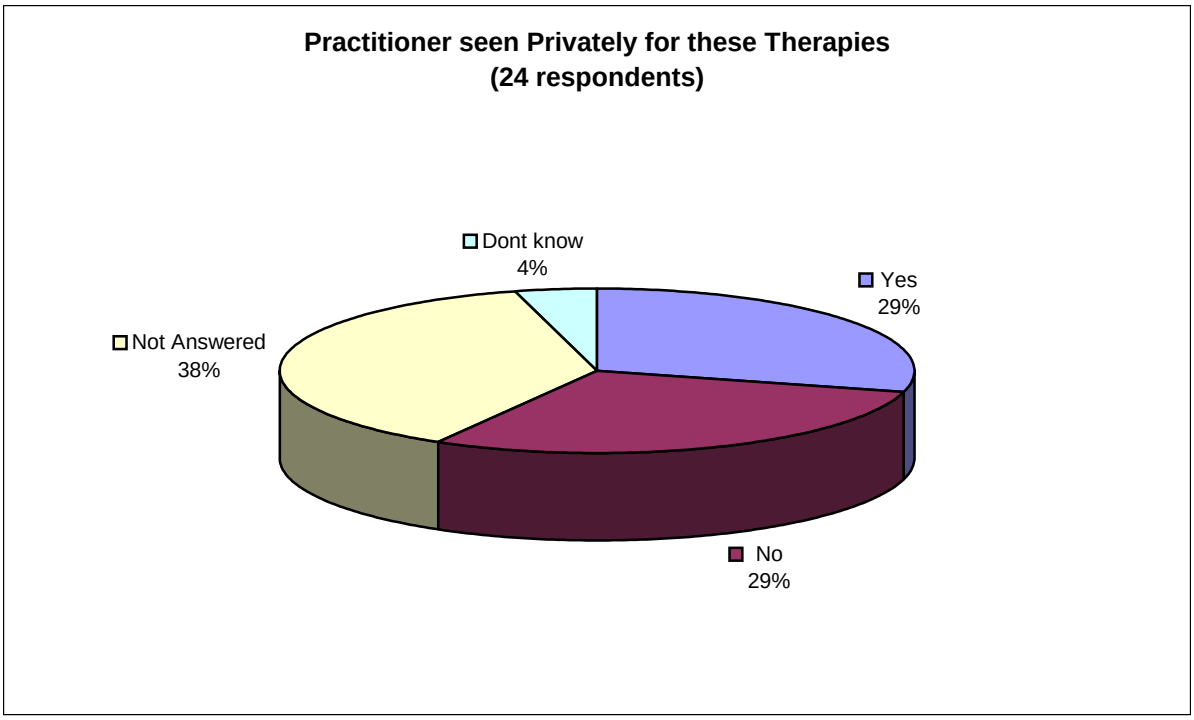
Question 19.a Were any of these Alternative Therapies offered on the NHS?

4 respondents answered yes to this question. 9 respondents answered no. 1 respondent reported that they didn't know 10 respondents did not answer the question.



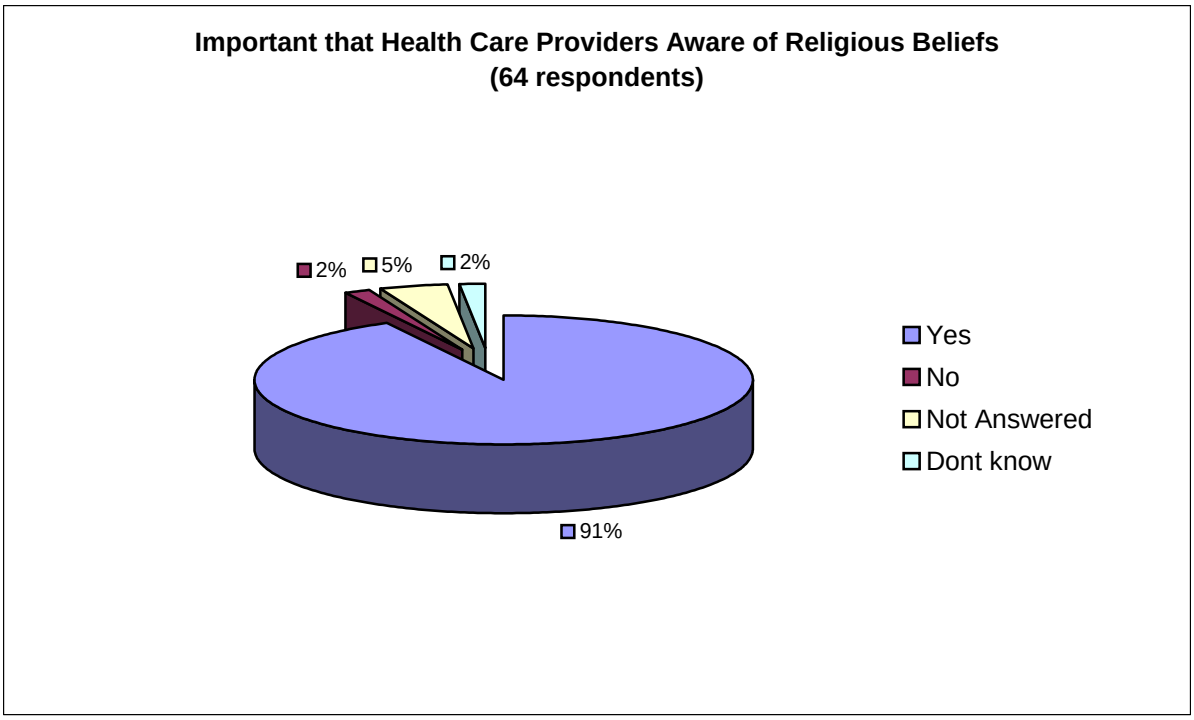
Question 19.b Was a Practitioner seen privately for any of these Therapies?

7 respondents answered yes to this question. 7 respondents answered no. 1 respondent reported that they didn't know 9 respondents did not answer the question.



Question 20. Do you think it is important for Health Care Providers to be aware of your Religious Beliefs and Cultural Needs?

59 respondents answered yes to this question of which 55 offered supporting statements. These statements are listed below (Question 20.1) and reflect the strength of feeling on this issue.
1 respondent answered no.
1 respondent reported that they didn't know
3 respondents did not answer the question.



Question 20.1 If Yes please explain.

Answers were as follows;

1) Most Non -Jewish Practitioners have no understanding of our community and therefore can make serious errors of judgement.

2) Yes - it's an essential part of who you are and our social dynamics are very different to other societies.

3) So appropriate responses can be made and avoid misunderstandings/misdiagnosis and for patient to feel more comfortable in a very distressing situation.

4) Yes - they need to respect cultural diversity. If you understand the culture, then the person's needs can be met.

5) Depends on the problem

6) Misinterpretation of results, misunderstanding of information & observational data.

7) Any treatment might affect the above.

Question 20.1 If Yes please explain. (continued)

8) Yes, they must understand where we come from.

9) Should be aware of peoples' needs.

10) Yes, very important.

11) Yes to understand specific Jewish problems, e.g. marriage, schools etc.

12) Yes especially issues around marriage education & not only on the physical side (family purity)

13) Yes - sometimes the degree of normal needs to be understood within social context. E.g. If a mother is upset/angry because after Pesach cleaning (Passover preparation) for 3 hours, and a child then brings a biscuit upstairs. A non-culturally aware care provider may consider this excessive, however someone with cultural awareness will realise the seriousness of this.

14) Belief Systems and cultural frameworks affect the context of mental health symptoms.

15) Yes, so they can deal appropriately.

16) So that they can suggest appropriate methods of care.

17) Jewish life centres around religion.

18) So that we would be able to get the right type of care, which would be applicable to our religious needs.

19) It would certainly be helpful depending on the patient. If it is a yeshiva (talmudic college) student, for instance, probably essential.

20) Yes, if a holocaust survivor, then dealing with specific history and its problems today.

21) Because it can affect the person, it makes a difference how they look at things.

22) Then they can tailor our needs to our religious & cultural needs, which will be more appropriate.

23) Without this they can't possibly understand peoples' needs and work to help them.

24) Very much so as it often is the cause or solution of the problem.

25) It must certainly help to understand the mores and cultural background, belief systems, ways of thinking.

26) Because they need to be treated accordingly. E.g. Male patient would require male doctor.

Question 20.1 If Yes please explain. (continued)

27) The cycle of Jewish life-each weekend, each holiday creates its own pattern of stresses that need to be understood.

28) Jewish marriage issues need to be resolved with due understanding of Jewish law.

29) I feel this is important because if the care providers know about the religious beliefs they will understand better why people with mental health problems act as they do and how to relate to them better.

30) Failure to have them taken into account not only shows a lack of care from the providers but for the members of the community can be detrimental to their progress and cause a regression.

31) Yes it is impossible to assess the needs of any person without recognising any needs, which is the effect of or pertains to their beliefs.

32) Yes so support can be given.

33) There are needs, which are specific to religious beliefs and cultural needs.

34) Yes, because there can be a clash between haskafa/halacha (Jewish Outlook/Law) and secular values and ideals which will affect treatments and suggestions.

35) Then one can understand where you are coming from and your needs.

36) Yes, to accommodate any special things we need.

37) There many religious factors which need to be understood and taken into account.

38) Religious factors need to be taken into account

39) Some questions they ask are not appropriate for the Jewish Community.

40) Yes, especially because we want to be guided according to Torah perspectives.

41) Some of the problems arise from or centre around religion. Some of the advice is more appropriate when understanding background and beliefs.

42) For some religion is a way of life.

43) In order not to contravene religious beliefs and norms when dispensing advice.

44) I feel it is important e.g. If a person suffers from OCD, it would be helpful for a
Practitioner to understand a little bit about the Halacha (law) of washing hands as these tend to be overdone by someone suffering from OCD.

Question 20.1 If Yes please explain. (continued)

45) Treatment must be made within the parameters of our religion, otherwise the clash within the patient's mind between his culture and his treatment would exacerbate the problem, not help it.

46) Yes, because being sympathetic to our needs means we can be better helped.

47) They have to understand me and my ideas in order to help me.

48) To understand, lifestyle, family situations, and if the therapy tallies with religious laws.

49) Yes, because they are certain concepts of modern psychology, which are opposing religious beliefs.

50) Yes, 1) So that they know what we can do/not do. 2) So that they will understand how our minds work. E.g. 1) That shabbos (the Sabbath) is an important day of the week. Not just a day of restricting/taking it easy. E.g. 2) That davening (praying) is our way of connecting to Hashem (G-d). It's not a religious act/asking for things.

51) It makes a positive impact on someone. In that way to be able to accommodate our personal needs.

52) Because the treatment should reflect his religious beliefs.

53) In order to help the person in a best possible way.

54) Yes, because it is very hard to go for help privately, if you would appreciate we need help from someone who understands our religion and provide it on NHS. Many people who cannot afford to go privately would be able to seek understanding help. I would like help, suited to our community paid for by the NHS!!

55) Definitely - we need to be more understood

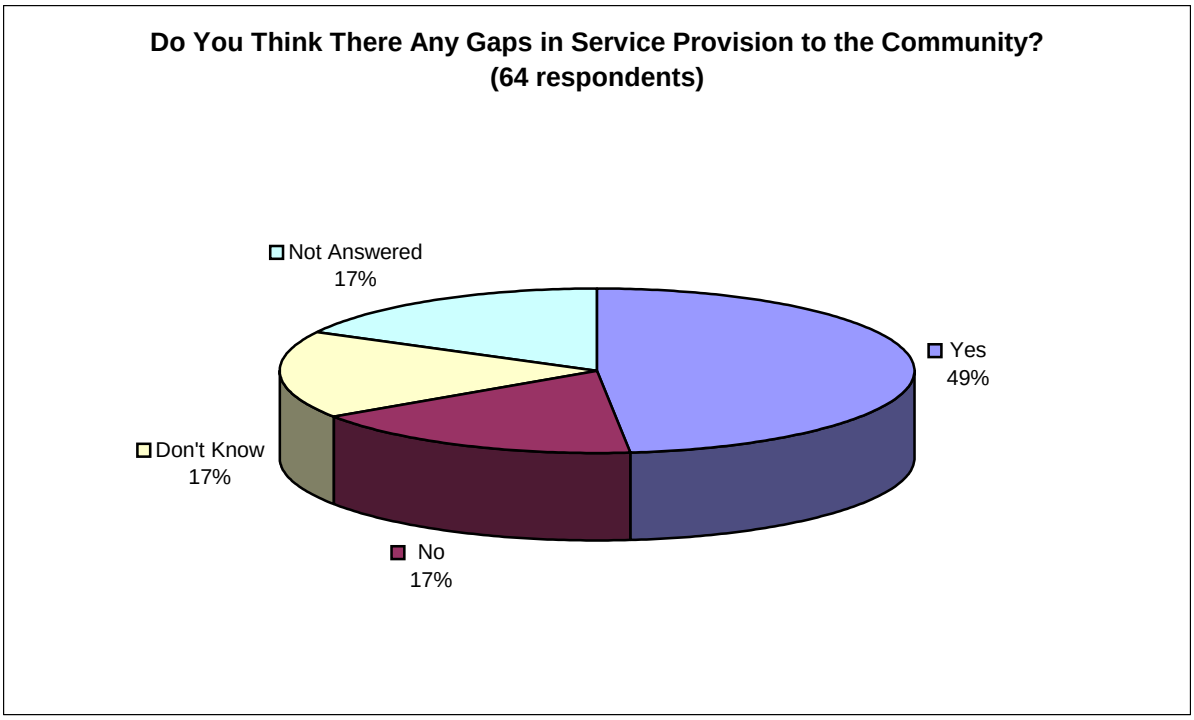
4 respondents did not offer any supporting explanation as to why they thought it was important for Health Care Providers to be aware of Religious Beliefs and Cultural Needs.

Question 20.1 If No please explain.

The one respondent who felt that it wasn't important for Health Care Providers to be aware of Religious Beliefs and Cultural Needs did not offer any explanation for supporting this view.

Question 21. Do You Think There Any Gaps in Service Provision For Members of the Community?

31 respondents answered yes to this question with 25 offering supporting statements, which show quite clearly what they would like to see.
11 respondents answered no.
11 respondents reported that they didn't know
11 respondents did not answer the question.



Question 21.1 If Yes please explain.

1) Lack of culturally centred service for the orthodox Jewish community. Most of the community are unlikely to trust non-Jewish or secular Jewish parishioners.

2) Not enough advertising and seeing private professionals is very costly.

3) Provision of facilities to carry out mitzvah (Jewish Law) observance. People who understand the different lifestyles, mores, acceptable behaviour etc. e.g. modesty.

4) People are worried about what others will think therefore the services provided are limited.

5) They do not understand our way of thinking.

6) No - but more fuss is being made about this - than is actual. Stigma within the community is a GREATER concern to people requesting and accepting help e.g. used by the close attitude to shidduchin. (introduction of potential marriage partners).

7) There are no NHS-funded religious mental health care providers

Question 21.1 If Yes please explain. (continued)

8) Orthodox social services.

9) Some more general correspondence with regards to modern day mental health problems could be a help to bring further understanding to the local community.

10) More advertising and write-ups in the Jewish orthodox papers and general post-ins.

11) Lack of ethnically sensitive provision & staff. Needs not properly understood and catered for.

12) a) Lack of knowledge on the part of the provider. b) The community requires its own providers.

13) To my knowledge there are no services dedicated to specific beliefs.

14) There is a question of social exclusion.

15) There is no religious Jewish child psychiatrist or woman psychologist.

16) Female psychiatrist. (lack of).

17) Lack of Jewish practitioners.

18) My friend who has a depression goes to a doctor and to counselling and has to pay money, which she can't really afford.

19) Her GP knows what she is going through and cannot help more than the medication.

20) No religious carers in health (mental) with no organisation incorporating religious needs.

21) I feel it would be a great benefit to people with mental health issues and their families if there would be more information available and support groups.

22) Private Counselling and CBT (Cognitive Behavioural Therapy) are very expensive.

23) The cost of psychiatric consultations is extremely high and with a large family and children with various problems, we have needed many consultations.

24) There is no NHS Psychiatrist.

25) Maybe a service for more orthodox people will be more beneficial.

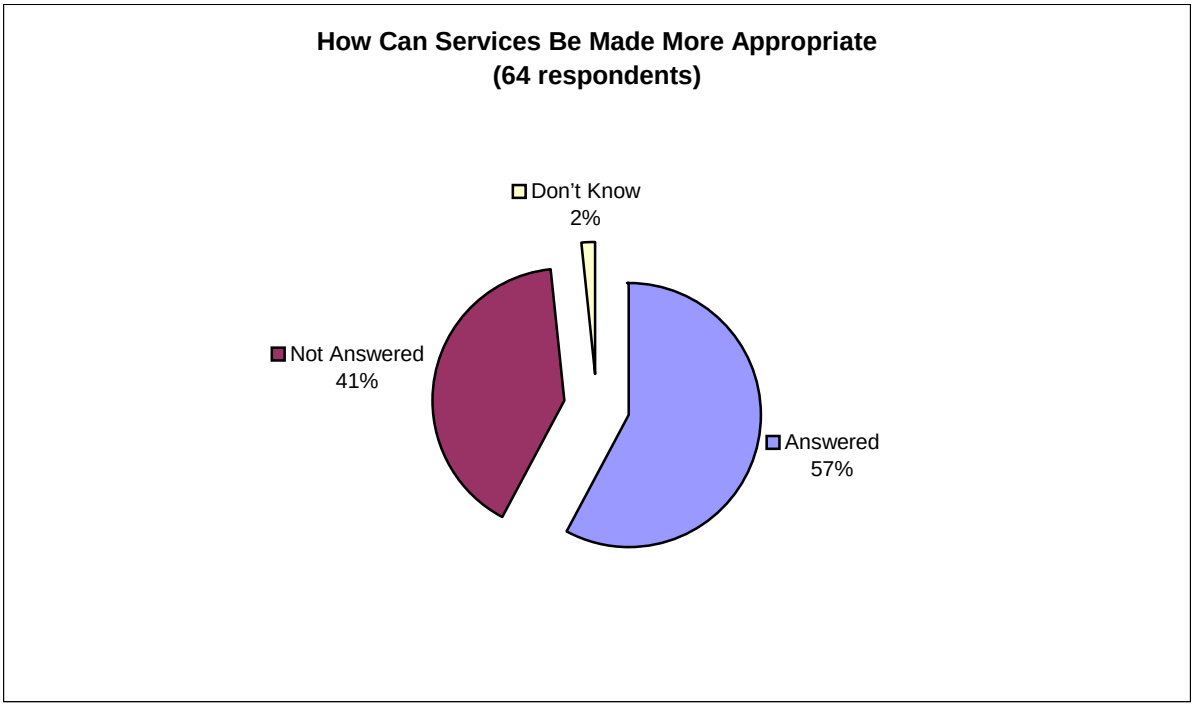
6 respondents did not offer any supporting explanation as to why they thought there were gaps in service provision for the community.

Question 21.2 If No please explain.

None of the 11 respondents who thought there were no gaps in service provision for the community offered any supporting explanation.

Question 22. How Do You Think Services Can Be Made More Appropriate and Culturally Sensitive?

Of the 64 respondents, 26 respondents did not answer the question.
38 respondents did answer this question, 1 respondent felt unable to answer the question as they had not needed or had any contact with such services.
The 37 supporting statements from the other respondents suggest a range of strongly held views.



The answers given were:

1) Employ Jewish people in key roles in these services or non-Jewish people with appropriate awareness training. b) A funded centre within the community.

2) Grants to help pay for counselling, etc for those who can't afford it.

3) Training given to existing staff and recruitment of staff from the orthodox Jewish community and/or paid/voluntary basis. Funded trained individuals within the community, based within the community who assist/attend with the individuals seeking services.

4) It should be sponsored by the NHS for community members on a low income.

5) Any legally (court) appointed guardian, psychologist or social worker must be culturally aware, knowledgeable & sensitive.

6) They should learn about our needs and have orthodox Jewish advisors.

7) The service providers have to work together with representatives & members of the orthodox Jewish community.

8) There are no NHS-funded religious mental health care providers.

9) Rabbinical approval and support.

Question 22. How Do You Think Services Can Be Made More Appropriate and Culturally Sensitive? (continued)

10) Frum (orthodox Jewish) professionals who understand needs. Training on the frum (orthodox Jewish) way of life.

11) I think they are already doing a pretty good job but must keep in mind who they are dealing with to become more sensitive to them.

12) a) Professionals receive ethnicity training. b) Professionals recruited from inside the community.

13) Have orthodox Jewish doctors, psychiatrists, psychologists, social workers etc.

14) To train & employ orthodox members of community.

15) More members of the orthodox Jewish community should be trained in recognising & helping where needed. Also, more financial help should be made available to the voluntary sector.

16) I feel that if the health providers know of the community's needs they will be able to relate to them better. This will ensure they are more sensitive.

17) Education. Employment of orthodox Jewish staff. Commission services from the orthodox Jewish community.

18) Yes, by training orthodox Jewish professionals.

19) More training and meetings about this.

20) Advertising.

21) More training of Jewish religious professionals.

22) By using orthodox Jewish health professionals & by educating local health care provider to our needs and cultural background.

23) Better confidentiality. Understanding of Jewish marriage.

24) I t shouldn't be so swept under the carpet. Psychological/mental disorders aren't something to be embarrassed about.

25) Making them understand Jewish ways of thinking.

26) Funding, Publicity, More qualified members in the community.

27) Maybe doctors, psychiatrists, community nurses could be given a course to help them be more sensitive to the Jewish community. The course could be built on comments and feedback from people who have gone through mental health problems.

28) By setting up departments devoted to their needs.

29) Use orthodox Jewish Practitioners, if unavailable - train more people in this category.

Question 22. How Do You Think Services Can Be Made More Appropriate and Culturally Sensitive? (continued)

30) By making practitioners more aware of our religious beliefs and cultural needs. By providing more information and support.

31) By sponsoring more orthodox Jewish mental care workers under the NHS.

32) People in turmoil should be supported by members of the community (confidentiality assured) without paying enormous fees.

33) Can be made better by having financial support.

34) Yes, if people who are accustomed with orthodox Jewish belief are trained to provide help.

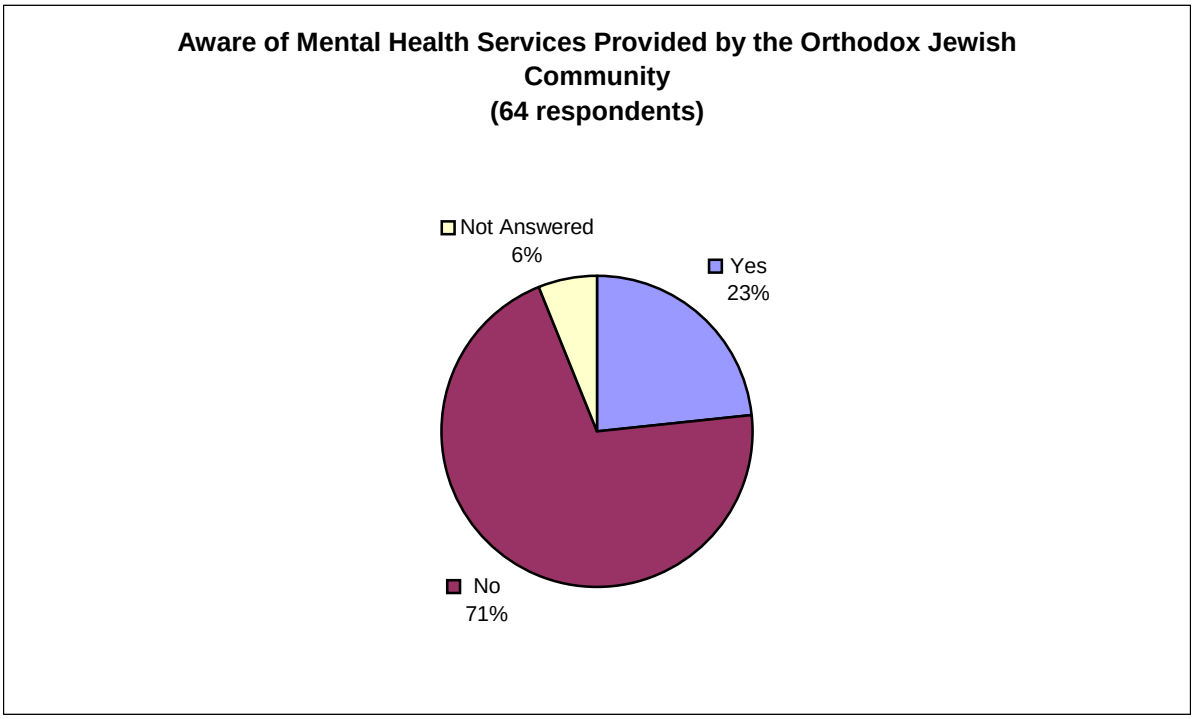
35) I feel the Jewish GP's are the most capable in understanding the community, and can help with those in need of such services.

36) To give funding to private psychiatrist from the community.

37) Have members of the religious community guiding or even providing the service if possible.

Question 23. Are You Aware of Mental Health Support Services Provided by the Orthodox Jewish Community?

45 respondents answered no to this question.
15 respondents answered yes.
4 respondents did not answer the question at all.



Question 23.1 If Yes – please detail.

1) Manchester Jewish FED.

2) FED has offered to help, but patient needs to want the help and be co-operative.

3) Have seen it advertised locally the support services.

4) Community Support Agency.

5) Am aware that FED are meeting these needs.

6) FED, Connections, Talking matters, Chizuk.

7) An organisation in London.

8) Some counsellors.

9) Helpline (by Rabbi Dr. Tomlin), Psychologist (Dr. Schauder), Counselling (Mrs Brunner, Mrs Brandeis, Mrs Ebbing), Dr Marshall. (All orthodox Jewish Practitioners)

10) A few private individuals trained to help with these problems.

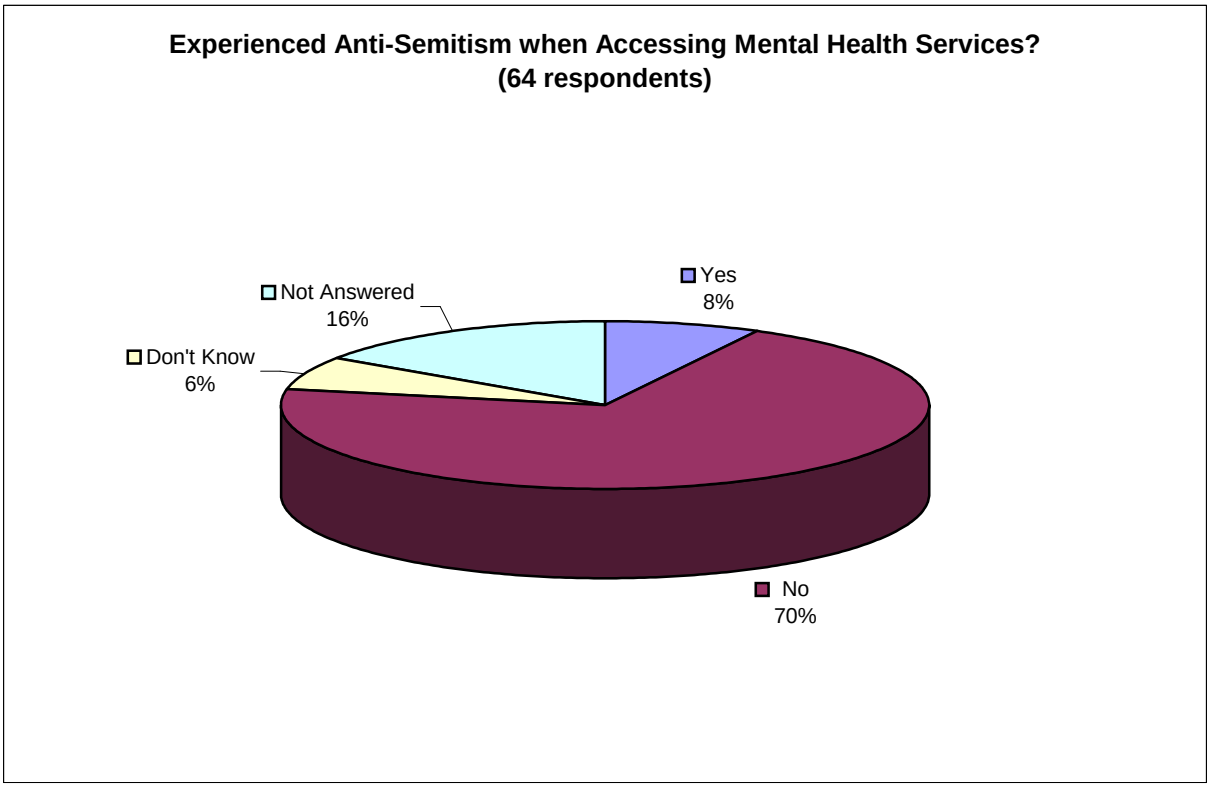
11) Phone in lines. Aguda creche etc.

12) Counsellors & CBT

13) Some GP's provide their support.

Question 24. Have You Ever Experienced Anti-Semitism When Accessing Mental Health Services?

45 respondents answered no to this question.
5 respondents answered yes.
4 respondents said that they didn't know.
10 respondents did not answer the question at all.



Question 24.1 If Yes – please detail.

Only 3 of the 5 respondents who answered yes offered supporting statements. These were:

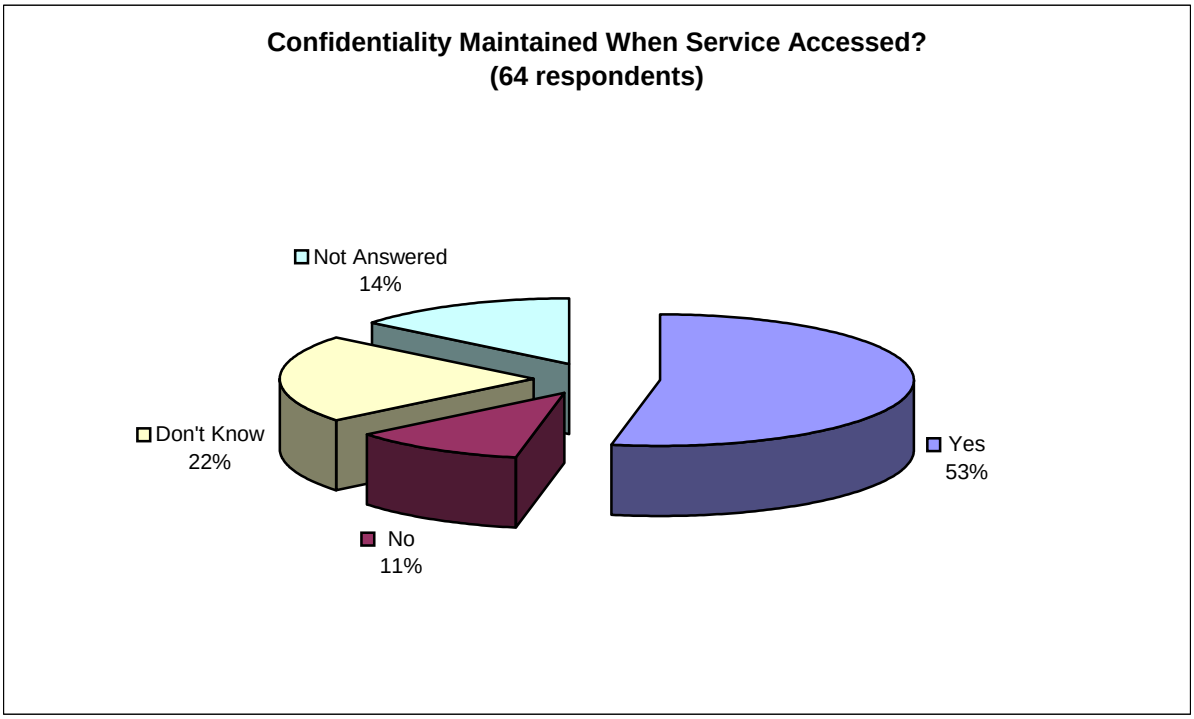
1) People shout at you in the wards.

2) Often people are told to move kids to less religious schools.

3) She told me once that when she told her she was Jewish she turned her nose and was very brisk and short.

Question 25. Do You Believe that Confidentiality is Maintained when Services are accessed?

34 respondents answered yes to this question
7 respondents answered no.
14 respondents said that they didn't know.
9 respondents did not answer the question at all.



Question 25.1 If No – please detail.

Of the 7 respondents who answered no the following 5 comments were offered;

1) I think the only good thing about secular services is confidentiality. Orthodox Jewish Community services do not understand the concept.

2) Within the NHS papers are freely distributed. The compass organisation breeched confidentiality within the community and it was very distressing for parents involved. I know of several (4) cases especially as some family details disclosed in the paperwork. You need to safeguard your own reputation.

3) Too much computerised recording.

4) When with an acupuncturist for treatment we were told of a close friend being treated for infertility.

5) My friends who have gotten a lot of help, no one knows unless they have told them - no one knows of the services they have used.

Question 26 Are there any other issues of a sensitive or intimate nature in your lifestyle that you would like to include on this form?

There were no responses to this question.

Question 26.1 Are There Any Other Issues?

5 out of all 64 respondents offered the following comments'

1) Problems with marriage (marriage guidance). Problems with child behaviour! (Dyslexia, ADHD.)

2) Professionals need to be aware of orthodox attitudes towards marriage, education etc.

3) Mikvah (ritual immersion)/marriage issues.

4) Help for children in school age who suffer from disorder.

5) When I was 15/16 I was depressed. The reason was that I felt that I'd done so much wrong that I could not understand why I was alive. I went about life pretty normally. No one seemed to notice. But deep inside I wanted to jump off a roof. Two factors kept me going, and eventually I sought the advice of a Rav (Rabbi). I discussed how to improve (NOT depression)
   A firm belief that Hashem (G-d) is right. What he does is good and has a reason. I even visualised the punishment I thought I'd get if I jumped. I put myself right into my learning (Talmudic studies). I cut off other thoughts and concentrated on Toras Hashem (G-d's Torah).
   Thinking back, it was basically these two things that kept me going until I plucked up the courage to go to a Rav (Rabbi). No secular person can understand these things fully

Question 26.2 Any Other Comments?

1) Absolute confidentiality by the service provider and any support services from within the community is fundamental to achieving greater confidence in people to consider using any services.

2) Primary experiences of some mental health assessments based on court mishandling of protracted court proceedings.

3) More orthodox Jewish professionals needed within our own community. Sponsorship for training suitable candidates.

4) (Approach towards mental health problems) - Family therapy - play therapy via qualified team approach needs to be available to community members. Impact of mental health issues on attachment and therefore profound impact on children. Practical help I.e. patient and gentle training towards Housekeeping - How to get children to school on time in clean clothes etc. is necessary-but requires a commitment to long term funding and sensitively offered support.

5) Religious private counselling should be available for all under the NHS.

6) I don't know of any provision at all and I have looked.

7) I feel that the community are generally unaware of mental health issue, especially mild issues which can be helped. As a result parents may not access help for children who display signs of worrying behaviour. They think that going for help would be blowing the behaviour out of proportion.

8) I think this project is a waste of time.

9) Thank you, good luck!

10) Keep up the good work and thank you for all the wonderful things you must do.

11) Grateful that you are aware of our needs and doing more to help us.

12) Good luck.

13) Thank you for all your efforts.

14) Wishing you much success.

Focus Groups

Two focus groups were held as part of this research project. The first with young married women who used the services of the Aguda Play Centre at Broughton Park and the second with a group of young men between the ages 17-20 who used a community centre called the "Cage" also in Broughton Park which was established and run by OJC Community Workers in the catchment areas we were working in.

Both groups were interesting for two reasons. Firstly the women's group was representative of a significant section of the community, young married women in their 20s and early 30s with an average of 4 children, of pre-school and primary school age. Secondly a small group of marginalised young men who have either "dropped out" or been excluded from schools at various points in their lives and who have not followed the normative path of going to a Yeshiva (Talmudic College) as almost all young men from within the OJC do between the ages of 16 to 19.

In addition these groups proved to be more accessible and responsive to requests for meetings than other representative groups from within the community, due to either work or study commitments from men, or lack of provision for common meeting places for older women for example.

The Women's Focus Group

This was conducted by our volunteer Miriam Lock and by Mrs Alex Silverstone of JEMS (Jewish Maternity Services). Neither had experience of running focus groups before and Miriam Lock's account of the experience is included below in a separate case study. The group discussion was organised thematically around broad questions on mental health subjects. The aim was to nurture discussion in a comfortable environment with the minimum obvious directing and prompting.

The items of discussion fell into the following headings:

- Views on Mental Health.
- Access to Mental Health Services.
- Experiences of Mental Health
- In an Ideal World What Services Would you like to see?

The last point was an attempt to open up the discussion to ideas which could eventually feed into our recommendations.

Views on Mental Health

The views on mental health were understandably varied. The researchers for practical reasons divided them into positive and negative categories. The negative included themes such as “funny thoughts”, “catatonic states” “intermittent feelings of crying”. Much of what was said described mental states which could be described as showing symptoms of depression, such as the ones above, and other examples of feeling lonely and cut off, a sense of giving up on things, and seeing no future. It is hard to tell whether or not this group of individual were talking of their own experiences or relating facts they already new about depressive states. However what is apparent is that none of the symptoms listed refer to some of the classic mental health conditions such as schizophrenia and bi-polar disorder, which suggests that the subjects were communicating common experiences from within the group.

The group was then asked to contribute positive thoughts about mental health. This list was much shorter but included counterpoints to the ‘negative’ list such as “feeling confident”, “able to cope”, “relaxed“, “satisfied“, “focused” etc. It was clear by some of the contributions that a healthy state of mind entailed the ability to function without stress or depression but also to be able to deal with day to day issues in a perceptively functional way. As one contributor put it, "to be able to act normally even when suffering from stress or depression".

The next area of discussion centred on the problems of accessing services which is one of the central questions of this research. Many of the comments are interesting and tie up well with some of the mixed responses to our questionnaire. The view of GPs was one of scepticism by some of the participants. One striking comment was “Some GPs give medication and tell you to go away”. Other contributors felt that GPs should be the “first stop”.

On the issue of Rabbonim (Hebrew plural for Rabbis) it was acknowledged that many people suffering from mental distress would consult a Rabbi before a GP. Others, however, said that they would not feel comfortable discussing their problems with a Rabbi.

Concerns about confidentiality were raised about consulting anyone from within the kehilla (Community) and that a useful suggestion was the need for a confidential helpline (which already exists within the community).

Much of the conversation used familiar words which are self-explanatory from within the OJC but require explaining for the non-Yiddish or Hebrew speaking reader. For example the group spoke often about the need to speak to a friend with the right *‘hashkofa’* (philosophy, or approach to life) which would be conducive to understanding emotional issues. This is clearly important for any group or individual who seek empathy from people they need support from. It is particularly important for a community where exposure poses risks both real and imagined.

What appears repeatedly in the transcriptions is the need for advice and support which is confidential, professional and non-judgemental.

Clearly the issue of stigma took centre stage in the discussions. Central to this was the concern over shidduchim (marriage) which is a highly sensitive issue in this community where poor "matches" or unsuitable marriage suggestions can be a result of prejudices and concerns of the history of a particular individual or family. Every parent aims for "good" or suitable match for their son or daughter and the general ignorance or fear over issues on mental health is seen as a prevention of a young adult's chance of making a successful match.

Contrasts were made with the secular world where it was considered that personal disclosure is like a badge of distinction and where mental health problems are spoken of public and glibly. By contrast secrecy and fear or public exposure is characterised from among these women. However many share the same stereotypes about the secular world due to lack of exposure and would be surprised that similar stigmatism exists in many communities on the issues of mental health.

The group turned to their many experiences of having depression and related mental health issues. One contributor showed an awareness of the work of the writer and comedian Spike Milligan citing him as an example as a famous person whose mental illness was a subject for his humour. Knowledge of popular cultural and media personalities is comparatively rare in this community but it also suggests that the OJC also can be influenced by the romantic notions of the wider world on the connection between creative genius (i.e. Spike Milligan) and mental illness. The same contributor made the point that "stupid people don't get down" suggesting that depression or getting down was the result of thinking about one's situation – also a common conception.

Others spoke of the general misunderstanding and many previous points were mentioned. But the common denominator was the sense of loneliness and isolation some of the participants felt when experiencing what appears from the evidence to be low level to moderate depression.

Others spoke frankly about their experiences of the NHS. One described how an elderly male psychiatrist made her cry. Another commented on how hard it was to get a good psychiatrist. The contributions in this section were at times difficult to read as they were honest and fully expressed feelings of loneliness and isolation among a representative group of women in the community. What comes across is that the women concerned do not feel supported by either the statutory services on the informal services from within the community.

Cultural sensitivity was also discussed but significantly given less emphasis than the issues above. The obvious points of concern were mixed wards, the non-recognition of religious requirements to keep the Sabbath and to eat kosher food. Also the existence of male nurses in hospitals was considered

inappropriate for religious women concerned about personal modesty and limited contacted with men other than husbands and close relatives such as fathers and brothers.

The section on what the women would like to see was especially full of comments. Some of the key points relevant for this study were:

- Mentoring in each medical centre – both male and female.
- The availability of group therapy for Jewish men and women. Separated by gender of course.
- An out of hour's helpline for those requiring advice and support.
- A centre for people to visit which is safe and culturally appropriate.
- Respite care for those caring for people with mental health problems.
- The need for culturally informed and sensitive counsellors - not necessarily Jewish but well trained and informed.
- More availability of crèche facilities to give mothers with large families and young children breaks during the course of a day or week.

Young Men's Group

The focus group was facilitated by Dean Cowan and Sholem Salzman with a particularly hard to reach and marginalised group of young men from within the OJC. All without exception came from established families from within the community. Most had been excluded from school at one time in their lives. At least two described themselves as suffering with ADD (Attention Deficit Disorder), and none had gone down the socially acceptable route of attending Yeshiva (Talmudic College) at an age 16-19 when most young men who had "made it" within the community would.

They were interviewed in an ad-hoc Community Centre nicknamed the "Cage" on the outskirts of Broughton Park.

By definition all of these young men were highly active and inquisitive as to what our purpose there was. One or two of them thought Sholem and I were there because we thought they were "mad".

Discussion was difficult. The young men were naturally rebellious as are many of their peer group within other communities and distrustful of two middle aged men who resembled in age and appearance their fathers. It took them a long time to sit down and contribute in a recordable way, but once trust was established their contributions were insightful and worth recording for the purposes of this research.
We started by trying to define mental illness. Most of the definitions were colloquial such as "Mash Heads" or "Smack Head" and appeared to have been inspired by bravado. Others provided more conventional definitions such as schizophrenia, depression and someone suffering with a nervous breakdown. One young man seemed concerned about self-definition as that because he occasionally felt depressed then he "must" be mentally ill.

We centred the discussion on support networks that they may access if they were feeling depressed etc. Several mentioned a particular community worker who acted as a mentor to many of the boys. They expressed how important it was for such a worker to have the knowledge and experience to understand “frum” (religious) kids who had problems and were marginalised because of their problems from within the community.

They also mentioned how reluctant their own parents were to consult professionals because of the stigma attached to children suffering with apparent mental health issues. In this they showed a striking similarity with the women’s group mentioning some of the same factors which encouraged silence of mental illness such as the problems with shidduchim and the judgemental attitude of the “community” due to lack of awareness.

Many of their own families would be reluctant to publicly admit to problems because of the above factors. They felt isolated and had nowhere to go other than to remain with their own peers with similar problems as themselves. Significantly one of their main causes of concern about sharing problems with others was the lack of confidentiality from within the community; expressing the same fears of exposure and vulnerability as the women’s group.

The nature of the group made lengthy and sustained conversation difficult and we concentrated as a result in discussing solutions to the problem of access to services. As a result the conclusions were short and concise and can be summarised as follows:-

- That the community needs more education on mental health issues and to have less fear of the “unknown”.
- There needs to be better access to culturally appropriate help with a specific focus on the needs of the young who feel estranged from the wider community.
- Many expressed their dislike over the word “mental” which they thought was prejudiced and outdated language.
- That services should be located outside of the community to ensure confidentiality and avoid gossip and stigma, signifying the characteristic mistrust from within this group.
- Some said they would prefer to speak to non- Jews as their general perception of Jewish figures with authority was that they were “unprofessional”.

Conclusions

Although the ideas and feelings from within these two diverse groups differ greatly they have some important points in common.

1. Mutual distrust of communal authority figures, whether it be religious, educational, or medical practitioners.
2. Mutual distrust of non-Jewish professionals such as NHS doctors, psychiatrists and nurses.
3. Fear of stigma particularly associated with not obtaining suitable marriage partners for themselves, siblings, children or other family members.
4. Perceptions of lack of understanding from within the community.
5. Perceptions of cultural insensitivity being a factor but not central compared to the first four points.
6. Perceptions of mental health were not unique to the OJC and reflected many of the stereotypes and prejudices from within the wider mainstream community.

DISCUSSION

After lengthy discussions and rigorous scrutiny of the collated data the project team believes that the Community Engagement Needs Assessment has unearthed considerable valuable feedback and data regarding both the Orthodox Jewish Community's perceptions of mainstream mental health provision currently available to members of the community and its views and opinions on the steps necessary to improve service design and delivery. Since this section is to an extent the subjective opinions of the project group we feel that it is important to reiterate the disclaimer presented in The Introduction Section namely that the views expressed here are purely those of the project group and are not those of either The Binoh of Manchester Management Committee, The Centre for Ethnicity and Health at the University of Central Lancashire, or NIMHE and should in no way be construed as being such.

Without wishing to repeat the points raised earlier within this report The Project Team feel that in order to fully appreciate the entire report, and particularly this section it is vital to 'set the scene' for this report. Within any tight knit, ethically compact community, sensitive issues such as mental health and wellbeing are notoriously guarded and difficult to prise open. Inside the Orthodox Jewish community this is complicated by the common practice of 'shidduchim' (arranged marriages). A practice often misrepresented inside the national media, within the Orthodox Jewish Community this takes the form of families being presented with names of prospective partners who, after thorough investigations, they allow their child to meet. The exhaustive natures of these enquiries mean that parents are often able to discover 'uncomfortable' facts about the prospective partner. Parents are therefore unwilling to admit health issues within the family and go to great lengths to disguise them in order not to affect any future marriage proposals for the person themselves or a sibling. This concern was raised constantly in both focus groups and was also mentioned in the questionnaire responses. Within a community where marriage and family life plays an absolutely central part it is hard to underestimate this issue's importance.

Both in the questionnaire responses and throughout the two focus groups this issue plus that of confidentiality within a close knit community and a lack of professionalism by community based practitioners were constantly raised. The suggestion was even raised that services should be located outside of the community to ensure confidentiality and avoid gossip and stigma, signifying the characteristic mistrust from members of the community. Although such a proposal itself contains inherent difficulties associated with the community's general fear of accessing services located outside the community its very suggestion graphically illustrated the centrality of this issue. This feeling of isolation leading to a silence to openly discussing issues around mental illness was a common thread throughout the research. Some people were even unwilling to discus the issue or complete a project questionnaire due to fear of being somehow 'labelled'.

Binoh has experience of this phenomenon through its work in the field of educational support and child development. The fears and concerns raised about mental health were similarly present in the community around admitting special education needs within the family. This impacted greatly on the support that could be given to the child both at home and in school and to the tools available for effective diagnosis of special education needs e.g. dyslexia, ADHD etc. Gradually over the past 15 years this fear and taboo has been lifted and the community has reached an acceptance of these issues and the need to support children and young people possessing special education needs. There has become a recognition that ignoring these issues does not mean that they go away but rather that they breed and reach a stage where effective support is a Herculean task. The Project Team sincerely hope that it is likewise to be believed that with the growing recognition within the community for the need for mental health support programmes the taboos currently existing around this area will similarly be lifted.

Another relevant point concerning the community was brought to our attention by Mr. Jeffrey Blemenfeld O.B.E. the National Co-ordinator of Chizuk U.K. (a support agency for those with mental health problems within the London Orthodox Jewish Community). The Project Team are extremely grateful that, despite a particularly tight schedule, Mr. Blumenfeld graciously allowed us a substantial portion of his time during a recent visit to Manchester in order to discuss the project and its findings. His observation, which linked in with feedback received through the report, concerned academic research undertaken by Professor Catherine (Kate) M Loewenthal Professor of Psychology at The Royal Holloway College (The University of London) and an internationally acknowledged expert in the areas of religious behaviour and religious, cultural and gender issues within the fields of both health and mental health.

Professor Loewenthal's research detailed the incorrect diagnosis by health professionals of mental health problems within the community. As described previously the Orthodox Jewish Community is demographically 'bottom heavy' with 48% of the population under 15 and average family size nearly 4 times the national average. Over 92% of households posses a child under 16 as opposed to 49% nationally and the community's annual growth over the last few years has been estimated at approximately 7%. Such high birth rates and the resultant large families have led to health professionals making the incorrect assumption that mothers coming to them expressing symptoms of stress or anxiety were suffering from Post-Natal Depression (PND). This is a very specific depressive illness that occurs after having a baby and can range in severity from a mild and normal period of mood disturbance ('baby blues'), through to Post-Natal Depression and the most severe and rarest problem (postnatal psychosis) and often requires treatment with anti-depressants. In fact Professor Loewenthal's research showed that the women were simply suffering from stress or anxiety caused by the situation within the household (obviously itself an issue of interest and concern but beyond the scope of this report) which thereby required an entirely different support and treatment regime. Many women were, therefore, suffering due to this misdiagnosis and

were not receiving the correct medication or treatment to overcome their difficulties.

The Project Team found this research intriguing as it linked in to a very interesting statistic uncovered during the research. Many of the community health professionals interviewed reported unusually high rates of PND amongst mothers within the community. Whilst national rates for PND are assessed at approximately 10-15% of mothers after birth, community health professionals were reporting that many (or even "most") mothers within the community were suffering from this particular disorder. Similarly 30% of questionnaire responders knew people suffering from the illness. The Project Team found this statistic startling and began to extrapolate reasons that may have lain behind this phenomenon. Whilst appreciating the knowledge and experience of these particular professionals The Project Team feel, that in the light of Professor Loewenthal's research, these comments must be treated with considerable caution and that it would be unwise to greatly extrapolate from them without further academic research or confirmation.

As the project progressed The Project Team began to notice a subtle shift in both the nature of the perceived problem and therefore the fulcrum of the research. There was an initial assumption based on the findings of a Community Report (Holman & Holman 2003) that noted that less than 1% of the community would access a non-Jewish voluntary organisation in the event of a personal crisis (be it financial, medical, family etc.). This fact is based upon the social and religious fabric of the Orthodox Jewish way of life which is of an all encompassing nature covering religious life, home life, inter-personal relationships, business and community life. In Lord Bhatia's words (Holman & Holman 2002) "a precise body of tradition, custom and religious law governs every part of life including work, education, food and leisure". The community sets specific standards of morality and personal conduct whereby mixing between genders is prohibited and schools are single gender. At public functions a 'mechitza' (partition) separates the genders and it is considered immodest to address a member of the opposite gender (except for family) by their first name. Different norms exist for acceptable music, literature, images and discussion material and mainstream culture i.e. television, films, magazines and internet use etc. is prohibited.

Linking in to these factors is the community's real and perceived fear of Anti-Semitic racial harassment. The distinctive dress and appearance of community members combined with the upsurge in Anti-Semitism noted recently in an all-party Parliamentary report have lead to 67% of the population being very or fairly worried about physical or verbal attacks when they leave the area as opposed to a national average of 16%. Throughout the focus groups and questionnaires the real (or perceived) fear of Anti-Semitism was regularly mentioned.

This was linked to the perception raised regularly in the questionnaires that the community's specific needs were simply being misunderstood or ignored by mainstream providers. The questionnaires elicited comments such as "service providers have to work together with representatives & members of

the orthodox Jewish community" and "doctors, psychiatrists, community nurses could be given a course to help them be more sensitive to the Jewish community; the course could be built on comments and feedback from people who have gone through mental health problems". It was, therefore, assumed that these circumstances have led to a situation where community members are either bypassed by exterior services or, when offered them, misunderstand the messages presented or otherwise decline to take up the support or information and that considerable numbers of people suffering from mental health difficulties and struggling to find support or treatment existing within the community.

As the project, however, progressed this assumption began to be queried and challenged by the information and data being uncovered. What began to emerge was a picture of people suffering from mental health difficulties attempting to cope with their circumstances and particular difficulties through the large numbers of 'gemachim' (voluntary organisations) based within the community. The Orthodox Jewish social ethos places a great emphasis on community activism and volunteering and a recent academic survey of our sister community in London noted volunteering rates over seven times the national average (51% as opposed to 7%). Those who have experienced difficulties or crises and have successfully overcome them are often willing to assist others undergoing similar experiences. A recent community directory listed over 200 voluntary organisations within the community running the entire gamut of personal and community needs including interest free loan societies, equipment loan groups, soup kitchens, community libraries, groups for counselling and caring etc.

Whilst both the questionnaires and focus groups detailed peoples' mistrust of mainstream support services and their perceptions of cultural insensitivity by the providers this did not mean that the people were going without help. Rather those with mental health difficulties were increasingly turning to these gemachim for support in a range of areas including counselling, advice, home support, food provision etc. Almost a quarter of all questionnaire respondents reported that they access community based support services. Interestingly this was despite the fears concerning professionalism and confidentiality that were raised previously, thereby indicating that these services were seen as the better of two evils rather than an ideal or adequate response to the problem.

The situation is also far from ideal for other reasons. Apart from the fact that it points to an effective abdication of responsibility from the mainstream providers, it also prevents additional support and resources from entering the community. Government funding of statutory services is based on the numbers accessing these services. If people from the Orthodox Jewish Community are bypassing these services there will be a subsequent lack of resources and support available for the community thereby impacting on the types of ethnically sensitive services that can be provided and discussed in the Recommendations section.

The situation also effectively places these people in the hands of organisations that, it would appear, often have neither the knowledge, capacity nor infrastructure to cope with their very specific needs. Almost all these organisations receive no statutory funding or input and are therefore run on a shoestring budget by well meaning community volunteers with little professional training or backup support. It is highly doubtful that such organisations can provide the very specific, wide ranging and often long term support that these people require. What tends to happen is either the group's capacities are stretched to breaking point by the needs of these people (thereby disadvantaging other needy community members) or the people receive inadequate support and provision. Several confidential discussions with directors of these organisations have subsequently confirmed these fears.

The fact that almost all questionnaire respondents noted the importance of mainstream service providers being aware of religious beliefs and cultural needs was not particularly surprising and linked in with similar research undertaken in other ethnic minority communities both here and abroad. What was interesting was that respondents noted how this knowledge was vital not just to make people feel at home but in order to give an effective professional service to those in need. Comments such as "Most Non -Jewish Practitioners have no understanding of our community and therefore can make serious errors of judgement", "So appropriate responses can be made and avoid misunderstandings/misdiagnosis and for patient to feel more comfortable in a very distressing situation" and "Yes - they need to respect cultural diversity. If you understand the culture, then the person's needs can be met" show how this knowledge impacts fundamentally on service design and delivery in ethnic minority communities.

To bolster this claim project research uncovered the case of an Orthodox Jewish man in London who, in the middle of a Mental Health Assessment, began to constantly stare out of the window at the sky outside. He seemed increasingly distracted and finally walked up to the window where, completely oblivious of the Panel Members in the room, he apparently began to talk to the wall. The Panel Members were naturally extremely concerned about this highly dysfunctional behaviour and, apprehensive at the possible psychiatric reasons for this, unanimously recommended that the man be detained for hospital treatment under the Mental Health Act 1983 (commonly known as 'being sectioned').

It later transpired that this was a severe professional misjudgement caused by an ignorance of the man's religious needs and requirements. What had happened was that during the interview, which occurred during a short winter's afternoon, the man had noticed that it was getting progressively darker and reaching the final time for him to conduct the afternoon ('mincha') service that Orthodox Jews are required to pray daily. Getting increasingly concerned that he might forgo the final time for prayer the man then decided to pray there 'on the spot'. What he lacked, however, was the knowledge and social skills to properly explain his actions to the panel (it may well be argued that this was a symptom of his mental health problems). What was in fact a

perfectly logical act within the man's religious beliefs was, due to ignorance, completely misunderstood by the panel resulting in an incorrect perception of his behaviour and thereby a miscarriage of justice by the relevant professionals.

Conversely this ignorance of the community's needs can make mainstream agencies unwilling to provide their services to the community (when they are in fact required) for fear of upsetting the community or just simply not to want to get involved with an unknown quantity. It is relevant to mention the case of a gentleman inside the community who for many years has suffered from severe schizophrenia and associated psychiatric disorders. Despite being a danger to himself and other community members (he once in fact injured his frail octogenarian mother) the mainstream agencies have been continually reluctant to intervene in the case. During a recent bout of severe dysfunctionality community leaders saw it as imperative that the man be detained for hospital treatment but were receiving little positive response from the Mental Health Trust. It was only after Binoh utilised some high level contacts inside the trust (formed as a result of this project) that action was finally undertaken and the man was indeed admitted for treatment. What most concerns activists working on the case is that without the implementation of effective ethnically sensitive rehabilitation and support strategies the man will merely revert to his previous pattern of a 'revolving door' policy. This means that when he is finally released back into the community it is without any adequate support framework and he is eventually re-admitted back into hospital (as has indeed occurred several times in the past).

It is relevant to note that The Race Relations (Amendment) Act 2000 placed new duties on public authorities to eliminate unlawful racial discrimination and promote equality of opportunity around service design and delivery. This mainstreaming of race equality in order to properly meet the needs of ethnic minority communities is no longer merely a goal that these bodies have to aspire towards but rather a statutory obligation incumbent upon them. Evidence from the Commission for Racial Equality and other monitoring bodies indicate that some seven years after the passing of the act many public authorities are still struggling to meet this requirement. Interestingly this fact was recently confirmed by the Chief Executive of a leading health services provider currently operating within Salford to a member of The Project Team.

The evidence collated by The Project Team and a range of questionnaire comments validated this concern. Comments such as "use orthodox Jewish Practitioners, if unavailable - train more people in this category", "by setting up departments devoted to their needs", "by sponsoring more orthodox Jewish mental care workers under the NHS", "by making practitioners more aware of our religious beliefs and cultural needs" and "by providing more information and support" were typical of the feedback received. In addition a common thread expressed by participants attending both focus groups was a strong mutual distrust of non-Jewish professionals such as NHS doctors, psychiatrists and nurses.

The cumulative effect of this feedback would seem that serious movement on the front of Orthodox Jewish ethnicity training and other similar programmes is fundamental to successfully addressing the needs of The Orthodox Jewish Community within the field of mental health support. Although it is appreciated that this may not always be easy it would be a sharp and effective tool in redressing the imbalances and inequalities in mainstream mental health service provision uncovered in both the questionnaires and focus groups.

RECOMMENDATIONS

Emerging from the findings of the project (focus groups, questionnaires and interviews) the following recommendations are seen to be most urgent and relevant.

- **1 The need for relevant professionals to undergo ethnicity training.**

As explained at length in the Discussion Section critical to relevant and effective service design and delivery and accurate professional judgements concerning the Orthodox Jewish Community is a basic knowledge about its values and beliefs. Whilst it is impractical to require exterior professionals to possess a detailed knowledge of all the various ethnic communities that they may encounter in the current multi-cultural United Kingdom, a rudimentary understanding of their values and beliefs can be expected. This is, however, especially relevant when working with a group such as The Orthodox Jewish Community whose ethos covers all aspects of members' behaviour including religious life, home life, inter-personal relationships, business and community life. Furthermore its standards of morality and personal conduct around acceptable behaviour and lifestyles are sometimes firmly in conflict with the prevalent, national norms. The different rules for acceptable music, literature, images and discussion material which thereby disqualify mainstream culture i.e. television, films, magazines and internet use put it in sharp contrast with the majority of the United Kingdom's population (of whom over 99% have television access).

- **2 The need for community based mental health workers.**

Linked to the previous point there is a particular need for community based mental health workers to service the needs of community members most directly affected by mental health issues. Over 90% of questionnaire respondents noted the importance of mainstream service providers being aware of religious beliefs and cultural needs. It was generally felt that this could best be achieved by the employment of a specialist worker and was summed up by one questionnaire respondent as the need for "Funded trained individuals within the community, based within the community who assist/attend with the individuals seeking services".

Linked to this development would be the appointment of a community representative to the Mental Health Trust's Patient Advice & Liaison Service (PALS). PALS is a national initiative that has been introduced to ensure that Mental Health Trusts listen to patients, their relatives, carers and friends, and answers their questions and resolves their concerns as quickly as possible. Such an appointment would go a long way towards dispelling misunderstandings and difficulties that often emerge during the rather tortuous and stressful mental health assessment and hospitalisation process and help create a climate of engagement between the Mental Health Trusts and the Orthodox Jewish Community.

As a mirror image of the above Mental Health Trusts could appoint a trusted 'link worker' representative whose responsibility would be to liaise with the community. Front line professionals and activists within the community most concerned with these issues would have a dedicated worker within the system who they could liaise with in times of crises. As detailed in the Discussion Section one of the most frustrating thing for community workers dealing with such cases is not knowing the relevant person to contact or being directed to someone who has little knowledge of either the case or the community. The appointment of such a link worker would effectively establish a 'hot line' that could cut through the red tape and bureaucracy and link them with someone who was aware of the case whilst being sensitive to the needs of the community.

- **3 The establishment of a mental health community supported employment project.**

The project research in particular through interviews and focus groups uncovered the difficulty of successfully reintegrating those with mental health issues into meaningful and competitive employment. Work is often seen as an important part of the recovery process for many people with mental health issues. Research undertaken by The United States Department of Health and Human Services (Substance Abuse and Mental Health Services Administration) has shown that:

- 70% of adults with a severe mental illness desire work.
- 60% or more of adults with severe mental illness can be successful at working when using supported employment.

The difficulties associated with reintegration into employment are magnified within an ethnic minority community such as the Orthodox Jewish Community which, as exhaustively explained earlier, has very specific needs around ethnically sensitive service design and delivery. Without such provision people with mental illnesses fail to receive any effective or structured care and support to aid their reintegration into the work and community environment. This has lead to these people spending ever increasing lengths of time aimlessly frequenting community venues e.g. synagogues and study halls. Apart from the obvious disruption and disturbance caused to those praying or studying, the lack of effective treatment often places these people in a 'revolving door' syndrome in that this lack of support means that they soon require hospital re-admission.

Interviews with both experts and practitioners revealed that this project would be best modelled so that participants would be expected to assist in all aspects of the project's organisation, administration and day to day running thereby equipping them with vital tools in their quest for permanent employment. Set up as a community based Social Enterprise it could access the considerable knowledge and experience that already exists within this field. Several socially minded entrepreneurs within the community have already given their support to the project and it is hoped that financial backing could be obtained from relevant mainstream bodies.

- **4 The need for community education around mental heath prevention and well being.**

Inextricably linked to the report's earlier recommendations would be the presentation of ethnically sensitive education to the community around pressing and relevant mental health issues. This would be a natural outgrowth of the community's increased access to mental health support services brought about by the report's earlier recommendations. By hosting a series of educational events for community members in an easily accessible community venue and presented by known and trusted health professionals the community's awareness of relevant issues would be tremendously boosted. The sensitivity of the issues means that, before the project's commencement, it would be vital to obtain written approval from respected rabbinic leaders within the community.

There are strong grounds for believing that such a programme would be both effective and successful. As explained in the Discussion Section the community has over the past two decades come to terms with a range of formerly taboo topics such as teenage disaffection, special education difficulties and women's health needs around cervical screening. By carefully planned presentations and dissemination of literature these previously 'forbidden' topics have been opened up to the community who have gained a greater appreciation of their relevance and importance. A similar community based programme highlighting mental health awareness issues could reap identical rewards.

In conclusion the project team would like to note that the Greater Manchester Orthodox Jewish Community has an estimated annual growth rate of 7%. The influx of new members from abroad coupled with various new housing projects will only accelerate this trend. With current government estimates that up to 20% of the population will suffer mental health difficulties sometime during their life, the issues and challenges detailed in this report will rise steeply in the coming years. It is up to service planners to take bold decisions to support culturally sensitive services to help those who are bypassed by current services and provisions. The consequences of ignoring this need are too worrying to contemplate for the people most affected, the local Jewish Community and indeed the entire population of Greater Manchester.

APPENDIX

1 LIST OF TABLES AND FIGURES

COMMUNITY ENGAGEMENT PROGRAMME

PROJECT QUESTIONNAIRE

FEBRUARY 2007/ADAR 5767

An independent project of Binoh of Manchester in conjunction with The National Institute for Mental Health in England and The University of Central Lancashire (Centre for Ethnicity and Health)

Broadhurst House
Bury Old Road
Salford M7 4QX
(0161) 720 8585

Charity Registration No. 1081366
Inland Rev. No. XR78955

PROJECT BACKGROUND

February 2007/Adar 5767

Dear Friend,

Binoh of Manchester in conjunction with local rabbonim and community leaders is undertaking a ***Confidential*** Community Engagement Programme. It will research the community's specific needs around mental health service provision and delivery. The information gathered is invaluable; it is the first time these issues have been addressed and will be used to plan future services within the community.

Trained workers from within the community will be gathering the information via anonymous questionnaires. ***We can absolutely assure you that all information will be treated with the UTMOST CONFIDENTIALITY; no names will be recorded and no identifying information will be passed on to anyone outside the research team. All information will be destroyed once the report has been compiled.*** All questions are entirely voluntary, full co-operation would be appreciated but any questions may be skipped. You may withdraw consent at any time, any information given will be destroyed and the questionnaire will be returned to you.

If you require any further information or have any other queries please contact The Project Director Rabbi Grant Binoh of Manchester 720 8585 or speak to one of the workers.

Thank you for your cooperation.

THE PROJECT TEAM

HELP US TO HELP YOU- PLEASE GIVE FULL CLEAR ANSWERS

RESEARCH INTO MENTAL HEALTH SERVICE PROVISION FOR THE ORTHODOX JEWISH COMMUNITY (OJC) IN GREATER MANCHESTER

PLEASE TICK THE APPROPRIATE BOX/HEADING

1. Age last birthday

16 – 18 19 – 21 22 –24 25 – 29

30 –39 40 – 49 50 – 64 65+

2. Gender

Male
Female

3. Ethnicity

Orthodox Jewish

Do you consider yourself? Sephardi
Ashkenazi

4. Were you born in the UK?

YES NO

If not, how long have you lived in the U.K. and Manchester?

U.K.	MANCHESTER
less than 1 year	less than 1 year
1 – 5 years	1 – 5 years
6 – 10 years	6 – 10 years
11 years or more	11 years or more

5. Citizenship

Are you a? British Citizen
Other

6. What is your first language?

Spoken

Written

Which languages are you fluent in?

Spoken

Written

7. Do you have a disability? Yes/No

If yes, please state

8. Employment status

Housewife
Full time employment
Part time employment
Self-employed
Working from home
Unemployed
Voluntary work
Student
Ill health
Disabled – working
Disabled – not working
Retired
Other (please detail)

9. Do you receive Benefits? – please tick

Incapacity
Income Support
Tax Credit
DLA
Housing Benefit/Council Tax Benefit
Working Family Tax Credit
Child Benefit
Attendance Allowance
War Pensions inc. reparations from Germany and Austria etc
Sponsored by family member
Other (please detail)

10. What does mental health mean to you?

11. Do you know anyone with mental health problems? e.g.:

Yourself
Husband/wife
Child
Any other family member
A friend
Member of the community
Someone you know
Other (please detail)

12. Do you know anyone suffering from any of the following?

Bi-polar disorder/Manic depression
Schizophrenia
Clinical to mild depression
Alzheimer's
Anxiety
Obsessive Compulsive Disorder (OCD)
Post Natal Depression
Phobias (i.e. claustrophobia, agoraphobia, irrational fears, fear of heights etc.)
Severe stress (e.g. caused by financial worries, marriage difficulties etc.)

13. Who would you go to see for help with a mental health problem?

G.P
Nurse
A&E
Psychiatrist
Rabbi
Approved Social Worker
Friend/family member
Other (please detail)
Don't know

14. Do you know what a Mental Health assessment is?

Yes No

15a. Have you or anyone you know ever been assessed?

Yes No

(If you answered No – please go to No. 20)

15b. If you answered yes to 15 a. was it carried out by?

Approved Social worker Doctor Community Psychiatric Nurse

Other (please detail) Don't know

15c. Was the person carrying out the assessment aware of your/their religious background and cultural needs?

Yes – please explain

No – please explain

16 After the assessment were you/they offered any support?

YES (please state)

NO

17. Were you/they offered any of the following?

1. Hypnotherapy/hypnosis
2. Cognitive behavioural therapy
3. Group therapy
4. One to one counselling inc psychotherapy
5. Other (please detail)

If they were helpful please state why

If not helpful please state why

18. Have you/they received alternative therapies?

1. Complementary medicines i.e. homeopathic remedies.
2. Reiki
3. Acupuncture
4. Nutritional advice.
5. Massage inc. reflexology.
6. Aromatherapy
7. Other (please detail)

If they were helpful please state why

If not helpful please state why

19.a Were you offered any of the above on the NHS?

YES NO

19.b Did you see a Practitioner privately for any of the above?

YES NO

20. Do you think it is important for Health Care Providers to be aware of your religious beliefs and cultural needs?

If yes please explain

If no please explain

21 Do you think there are any gaps in service provision for members of the community?

YES NO

IF YES – please detail below.

22 How do you think services can be made more appropriate and culturally sensitive in meeting the needs of the Orthodox Jewish Community?

23 Are you aware of mental health support services provided by the Orthodox Jewish Community?

YES NO

IF YES – please detail below.

24 Have you ever experienced anti Semitism when accessing mental health services?

YES NO

IF YES – please detail below.

25. Do you believe that confidentiality is maintained when services are accessed?

YES NO

IF NO – please detail below.

26. Are there any other issues of a sensitive or intimate nature in your lifestyle that you would like to include on this form?

YES NO

Are there any other comments that you would like to make?

If you would be willing to undertake a confidential, in-depth interview or be part of a group discussion (focus group) please contact Rabbi Grant (720 8585).

THANK YOU!

THE PROJECT TEAM

REFERENCES

- Holman & Holman (2003) The Orthodox Jewish Community in Broughton Park-a study.
- Cantle et al (2002) The Home Office Community Cohesion A report of the Independent Review Team
- Holman & Holman (2001) Torah, worship and acts of loving kindness-Baseline indicators for the Charedi community in Stamford Hill.
- Salford City Council (2004) Salford Drug and Alcohol Action Team Audit.
- Manchester TEC et al (2000) Analysis of the Broughton Park Jewish Community Employment Survey.
- Keith Brook-Office of National Statistics (2004) U.K. Labour market data for local areas by ethnicity.
- Office of National Statistics (2003) U.K.
- Figures obtained from individual schools.
- Ofsted Inspection Report (2003) Salford L.E.A. Page 5.
- Kershaw (2001) British Crime Survey-Statistics for ‘inner city area’.
- Gordon (2000) Poverty & social exclusion in Britain.