

UNIVERSITY OF CENTRAL LANCASHIRE
Centre for Ethnicity and Health & The NIMHE Mental Health Programme

A REPORT ON THE COMMUNITY ENGAGEMENT PROJECT
A RESEARCH PROJECT FOCUSING On

**“EMOTIONAL EXPERIENCES & ATTITUDES of
ORTHODOX JEWS IN STAMFORD HILL”**

A needs assessment of Mental Health Services, in the
Ultra Orthodox Jewish Community of North London

Talking Matters Wellbeing Centre
Stamford Hill, London

by

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TALKING MATTERS (TMA)

TMA was set up in 2001 to provide stress prevention in the Orthodox Jewish Communities (OJC) of England. Among other things, it provides training and education, counselling, psychological and complimentary therapy services to the OJC's of North London and Salford, pre-dominantly to Holocaust survivors and their generations as well as Cultural Awareness Training Seminars (CATS) to non Jewish service providers.

THE TEAM

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

Ms José Martin

Ms Martin originally trained in Art & Design, later emigrating to Israel and then living in Iran (prior to and during the Iranian Revolution.) Upon returning to the UK, she retrained as a Youth & Community Worker, establishing and running youth clubs and community centres, working with various minority ethnic communities from the young to the elderly. She has over 26 years experience in Community Development Work, having established 3 thriving Charities (the much feted Dalston Youth Project, Chizuk and Talking Matters).

Prior to this research, she commissioned one other piece of research, "Attitudes to Pre-Marriage Education in the OJC of North London" 2003 with Royal Holloway University of London. She lives in the orthodox Jewish community, is the National Director of Talking Matters, which provides counselling and therapies to Orthodox Jews most of whom are Holocaust survivors and their generations in Stamford Hill and Salford and employees over 30 therapists, 5 researchers and 5 administrative staff. She has two grown sons, a new first grandson and speaks Hebrew, French and a little Farsi. Ms Martin has been a part-time MH service user for over 37 years and is now 56 years old..

Mrs Shani du Sautoy, B.A., M.A., Dip Psyc.

Shani Ram du Sautoy is a researcher in psychology. She has conducted research in the area of women's issues, and mental health at the University of East London. Her interests are women, mental health and the negotiation of: work, motherhood and relationships in a modern western society, She also worked with mentally ill young people teaching multimedia design and conducted a multimedia group at a day centre in North London for people with enduring mental health issues. Shani has a post graduate diploma in Psychology, is a member of the British Psychology Society and has a Masters in multimedia from Central Saint Martins, London University School of Arts & Design. Under her previous role as a multimedia designer, she led a team of multi disciplined designers at the Design Laboratory, St Martin's School of Art to research and create innovative design products and projects. She lives in North East London, is married, a 39 year old mother of three children and has a cat.

Mrs Suzanne Cohen

Suzanne gained a BSc (Hons) in Psychology from the University of Bradford in 1983 before training to be a Social Worker at the University of York. After gaining her Masters in Social Work and C.Q.S.W. in 1986 she worked mainly as a child protection Social Worker for the London Boroughs of Westminster, Southwark, Barking, Dagenham and Enfield in area and hospital teams until 1995. Whilst working as a Social Worker, Suzanne trained for three years with the Pellin Institute in Gestalt therapy and contribution training. In 1996 Suzanne gained an MSc in Social Research from the University of Surrey and worked on several health related research projects until the birth of her son in 1998. After spending three years as a full-time parent, Suzanne managed the administrative office for the Social Research Association before leaving to take up a post with the London Borough of Camden as a Breastfeeding Counsellor in 2005. Suzanne has also volunteered for the La Leche League, an international breastfeeding organisation since 2002, leading discussion groups and working on the helpline. Suzanne, in her forties, was very pleased to take part in this project and help increase understanding of the emotional needs of the Orthodox Jewish Community.

She has published several articles and books including; Children as informal interpreters in GP consultations; Primary Health Care Services for Children from Ethnic Minority Groups; Child psychiatry and child protection litigation.

Miss Shulamis Abraham

Miss Abraham has lived in Stamford Hill all her life, attending Yesodey Hatorah School and Beis Yaakov Seminary, where she completed her A levels. She is currently completing her studies at MST college, having benefited greatly from its Religious Philosophy course, and a BA degree course in Humanities.

She has enjoyed her experiences in teaching, outreach and social care and; volunteering- for Talking Matters Association. It was the volunteering that resulted in her becoming a member of the Community Engagement Programme research team- which has proved an enriching and eye-opening encounter for her as the youngest member of the team (aged 19).

Dr Ruth Anne Cohn

Dr. Cohn is a Clinical and Educational Psychologist educated at UCL, London, where she studied for her first degree in Psychology (First Class Honours) and her Doctorate on the "Causal Nature of Perception on types of response to repeated failure with especial reference to Frustration and Aggression". She then completed her training as an Educational Psychologist at the Department of Education in University College. Following this she completed her M.Sc., in Abnormal Psychology at the Institute of Psychiatry, University of London. Her research was on the variability of reaction time in brain-damaged patients in their middle years.

She has worked as a Clinical Psychologist at various specialist Hospitals in the London Area having set up the Department of Psychology in the Psychiatric Unit at Whittington Hospital after having worked at Friern Barnet Hospital's and Halliwick's secure and acute wards. She has also worked at the Northgate Clinics for disturbed adolescents and the Department of Medicine at the Central Middlesex Hospital in Acton. She has enjoyed a long career in clinical work with adolescents, addictions, acute and chronic mental health problems, ex-prisoners and recidivists and the entire clinical spectrum of anxiety/depression, bipolar disorders, schizophrenic illness and eating disorders. She has worked with children with behavioural and learning difficulties, including school refusal and truanting. She is a trained marriage and couple counsellor as well as a therapist for sexual dysfunction in both men and women. She has brought up six children who are all working in the general /mental health field. She is a practicing Orthodox Jewish professional who is able to communicate fluently in five languages.

Since her retirement she has concentrated on her private practice within the NHS System and in GP. practices. She has taught Psychiatry in the Islington School of Midwifery and to medical students on their psychiatry rotation. She has also taught mature students within the University of London and participated in large-scale longitudinal studies of the developing child, as well as being employed as a trainer on the Talking Matters Counselling diploma course and takes clients through the Talking Matters CHOICES Programme.

Mrs Leah Feldman

Leah Feldman, originally from Montreal, Canada has made her home in Stamford Hill, London, England for the past fifteen years. She is a thirty-seven year old wife and mother of seven lively children. Leah has studied special education in Canada where she has obtained a diploma in special needs and has worked in this field. In July 2004 she qualified as a counsellor with an Advanced Diploma in Therapeutic Counselling, accredited by the CPCAB (established by TMA). Since then Leah has been doing counselling work within the community as well as attending workshops within this field.

Dr Nadia Loewke-Kinn (MSc Psychology, MBBCh, LFHom Med)

Dr Loewke is a fully qualified GP, graduating in South Africa from the University of the Witwatersrand Medical School in 1995. Previous to that she studied Clinical Psychology, graduating with an MSc degree. She is also a Medical Homeopath, registered with the Faculty of Homeopathy (LFHom Med) and currently studying Traditional Chinese Medicine and Acupuncture, taught by the Beijing School of Chinese Medicine.

Her special interests include Psychiatry and Complementary Medicine. The possibility of combining these fields is very exciting. There is a demand for non-conventional approaches in the treatment of disease and she is exploring these possibilities in her general work. A combination of approaches enables her to see the patient in a holistic way, rather than in an insular and narrow way. She is currently employed at the Homerton University Hospital, where she has been working as a Staff Grade Psychiatrist on and off for approximately the last 9 years. She is also a consultant to Hatzolah (orthodox Jewish ambulance service) and works with Chizuk (only Orthodox Jewish facility in UK for those with severe MH issues, established by Talking Matter's National Director) in an advisory capacity. Although she works independently in the community, she also liaises with the Rabbis and Rabbinical Judges when the need arises.

Other interests include Solution Focused Brief Therapy, anxiety, anger management and addictions.

Reb. Nota Kreiman B.A., M.A., P.G.C.E. Dip Psych

Rev Kreiman has been a resident in Stamford Hill since 1984. He studied English at Cambridge and later trained as a teacher. He has been a Chassid* for many years, studying in two Kollelim (Married men's colleges). He is qualified in three psychotherapeutic approaches with five years experience and works predominantly with men over sixteen and married ladies. Through his work he enables clients to access fully their subconscious, discerning and remedying the roots of their negative feelings and behaviour, releasing among other things, emotional pain, fear, phobia, and traumas.

Mrs Malka Taub Adv Dip in Couns. P.G. Dip in Child Focused Systemic Practice

Until 1989 Mrs Taub worked in a property developer's in office administration. In 1990 she made a career change and joined the Talking Matters 3 year counselling course at MST College, qualifying as a counsellor in 2004 and later at the Institute of Family Therapy, Birkbeck College, London. She works with individual clients, using the Person – Centred/Humanistic/Rogerian model.

She has a particular interest in family and child focused therapy and in 2006 qualified as a Systemic Practitioner, joining a multi-disciplinary team in one of the NHS Child and Adolescent Mental Health Service (CAMHS). Her work with children and their families is through the Systemic approach that focuses on relationships and family systems. She now undertakes supervised work with children with emotional and behavioural difficulties and also families experiencing marital and post-divorce issues. As part of her professional work with children and their families she works directly with children in an educational setting to support them in their emotional development through the application of play therapy.

Mrs Taub, lives in Stamford Hill is a mother of many children and a grandmother and in what spare time she finds, devotes herself to community work.

*

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We wish to thank the following people who supported this project, giving of their time, knowledge and expertise (in alphabetical order)

Ms Sue Balmer	Head of Mental Health, East London & City Mental Health Trust (ELCMHT)
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Mr Jimmy Glass	North Sector, Mental Health Locality Teams, L. B. of Hackney (LBH) steering group member
Mr Nand Gopal	Manager, Emergency Psychiatric Unit, East Wing, Homerton University Hospital
Mr Berol Hammer	Service user, steering group member
Ms Lisa Heywood	Consultant, Service user, steering group member
Rabbi Chaim Kantor	Counsellor
Mrs Yvonne Leigh	Counsellor
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Ms Olivia Nuamah	Race Equality Lead, London Development Centre, NIMHE
Mr Imre Posonyi	OJ Social Worker and Reflexologist
Mrs Evadne Stern	Social Worker
Mr Doug Tilbury	Social Worker, LB Hackney, Children at Risk dept, steering group member
Mrs Susan Woollacott	Manager CAMHS, City & Hackney NHS Primary Care Trust

*

One of the difficulties in managing the steering group, was getting continuity of attendance so that the same members attended meetings. Invariably, due to the work load of the key agency members, less than a handful of members were able to attend all the meetings at the same time.

Additionally we wish to acknowledge and thank all the interviewees, especially the members of the Stamford Hill Orthodox Jewish Community (OJC) who have been the willing participants in this unique research programme, without whom this work could not have happened. It is their transparency and bravery in allowing the researchers into their lives and homes which has formed the basis of this research.

May their strength and resilience enable further changes in attitudes within the OJC and, pave the way for more appropriate services from the statutory providers.

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* See Glossary

1. EXECUTIVE SUMMARY

The Community Engagement Programme has been part of Department of Health (DH) and National Institute for Mental Health England (NIMHE) scheme, administered by the University of Central Lancashire (UCLAN) through its Centre for Ethnicity and Health. In this round the over arching aims were governed by central government priorities of Delivering Race Equality (RRE), to enable Black and Minority Ethnic (BME) community groups across the country to engage community members (and not academics) in conducting their own research projects in relation to mental health and race equality. As a direct result of this programme invaluable data, attitudes and behaviours have been unearthed on the issue of mental health. Additionally in the process, many “ordinary” community members have been given a unique opportunity to become part of the academic world, learning about the planning, execution and actual research of the issues at hand and some have also taken up the wonderful opportunity of qualifying in basic level research. In respect of this report the BME was the Ultra Orthodox Jewish Community of Stamford Hill in North London.

The project was undertaken by Talking Matters, predominantly with its clients who use the counselling and therapeutic services in its London office (there is also a Salford office). This was in the heartland of the Chassidic community, reknown all over the world for its insular way of life, even among other Orthodox Jewish Communities (OJC). Most of the OJC lives in the London Borough of Hackney with about 10% in the south of Haringey. The community is rapidly growing and may soon be over populated with many schemes proposed for moving to other areas to alleviate the growing housing shortages and problems. Stamford Hill, is made up of 2/3 local population being OJ alongside many other BME communities in the area, notably Asian, African/Caribbean and Turkish.

In the wider world, little is known about the OJC, there are perceived as a “hard to reach” community. Talking Matters provides ongoing cultural awareness training seminars on a rolling basis in London and Salford. Within the community there are differing religious and ethnic groups, ranging from Hungarian (the predominant grouping) through German, Polish, Moroccan, Indian and French. There is much poverty too, compacted by low incomes, large families and school fees for private, un-funded OJ schools. The way of life is distinctly different from that of its neighbours, in beliefs, attitudes and behaviour which are borne out through cultural norms, language, gender roles, crime (or lack of it) literature, music, media and youth culture. The Internet is prohibited by the Rabbis, who make the moral decisions in the OJC, and therefore most homes do not possess one, although it is allowed for in the work place. Stamford Hill has the highest child birth rate in Hackney (5.9% vis a vis 1.6 nationally, Holman and Holman) insuring that children’s services and education are the natural priorities for the future of the community.

As a voluntary sector community organisation and charity providing talking and complimentary therapies for the past 6 years, Talking Matters has witnessed a sharp increase in service take up. There has been a slow but gradual lessening in some quarters of stigma around mental health. “People are not scared of the *disorder as much as they are afraid of the social reaction.*” In the last 3 years in particular, through the Choices Programme funded by Neighbourhood Renewal Fund (NRF) and the City & Hackney NHS Primary Care Trust (PCT), there has been a sharp incline from 6% - 38% take by men (450% increase). Additionally there are daily requests by parents to provide counselling for their children and youth, many of whom are presenting problems of disaffection, anti social behaviour in OJ terms and exclusion from home and/or school, a phenomenon completely unheard in the OJC until recently. “*Eating a bacon sandwich, it really is a spiritual suicide but also...young people are using Class A drugs and alcohol*”

Divorces are now almost at the national level (Board of Deputies of British Jews) which itself is quite a shock to the community and the leaders are beginning to realise that the social fabric of the community is starting to fray at the edges. ‘*The issue of not being allowed to behave angrily can be seen as oppressive*’ This poses a huge problem, as historically the community has been held together by the strong religious and ethical frameworks set down by its beliefs in the Torah and the teachings of the Rabbinical forebears. It is a fact that the community leaders no longer have the time, skills or experiences to be able to assist in many of the issues presented before the. The way of life was historically thought to protect all community members from the morays of the world at large, as a means of self protection, a community within the community, however the fall out has become a growing problem for the community leaders, teachers, parents and children themselves, as the fabric of the society is unavoidably influenced and diluted. ‘*Young people have a lot of temptations from secular society*’

Part of the waft and weave of this fabric, has always been the commandment to “Go forth and multiply.” This commandment has underpinned parents’ needs to marry off their children, but unless ones offspring is seen to be behaving properly this can cause stigma for the family impacting on the siblings and indeed generations. Fears of such stigma have become part of the fabric of the community and members are now so accustomed to denying any issues of mental ill health, that it has no place in their lives, as one

respondent said, *"You have to be on your best behaviour because you never know whether other people are watching"*

"Mental health (MH) issues are part and parcel of this living in denial, if there are no mental health issues, then there is no need for information. No culture or language specific information has been available to or about the community regarding mental health, so this gaping chasm of information was the catalyst for this project.

The aims of the project were to un-pick the myriad of beliefs and attitudes to mental health as well as discovering the level of service take up and the preventing barriers to that take up. Therefore, in order to conduct a thorough assessment of mental needs in the OJC and to have the Rabbis' blessings the research team compiled two questionnaires, one for the service users and clients and the other for the service providers. All team members were recruited from the OJC, both from the community itself and the wider Jewish community, all residents of Stamford Hill. The make up of the OJC is 80% Eastern European immigrants and Holocaust survivors and 20% Middle Eastern. Due to the sensitive nature of mental health the most senior Rabbi of the community "The Rov" was consulted at the start to ensure he was "on board" and aware of our intentions and methods.

The Torah underpins the whole belief system and way of life. The Rabbis, community leaders and teachers promulgate the teachings of the Torah and its commentators, ensuring that the traditions are passed from generation to generation. The community leaders play a major role in the community and everyone adheres to their decisions. This can cause problems when if they don't have the time or expertise, the community member finds he/she might disagree with the outcome or suggestion. Community members have historically always "behaved" themselves and done the same as every one else, if there are noticeable differences however, on a day to day basis, judgmentalism does at times take over from the religious, ethical and social teachings of Torah. As a result community members are beginning to air their own opinions and disgruntlement about some of the normative opinions on youth culture or divorce for example. The youth have begun to not listen to their parents *"Doesn't know if young people concerns are taken seriously....I think there is a lot of peer pressure in this community"*

Understanding of mental health, as there has always been an all encompassing "Route to heaven" via the Torah, its teachings have not swerved from commanding its adherents to talk about their problems and relieve the heavy heart. What has side lined those teachings are the history, experiences and interpretations, so that fears have over ruled sense, stigma has take over from addressing the issues and denial has become the modus vivendi. As a direct consequence, if everyone is in denial, there has never been the perceived need to produce information in the languages needed about mental illness.

Service take up

This has always been inhibited by fear, fear of what "they" the social services or police would do. Then there is also the fear of the possibility of having ones way of life challenged or even changed, the shame of having ones' dirty linen aired in public or the horror of discovering someone in the family is not behaving properly. So using these services has always been the very last option used by this community - until recently.

Added to the community's reticence has been the service provider's slow response to change, ensuring that all communities have access to the services they require. There has even been a reluctance in some quarters to implement change, despite the fact that departments have been aware of some of the needs but have chosen not to use the information to provide culturally more appropriate services. (87.5% knew about Holydays and festivals but only 50% accommodated those needs, i.e. 37.5% did nothing) A commonly held belief in the OJC is that the statutory services think *'...the OJC can afford to look after itself'* but more importantly the fact that although some service users want to have the option of non Jewish services, for confidentiality, the great majority prefer an OJ service. *'A shared value system of an Orthodox Jewish counsellor'*

Practically the main suggestion for improvement is that the service needs to be 24/7 and staffed with at least one or two OJ practitioners.

Women

There have been some heart-rending accounts and uncomfortable truths coming to the surface during this exercise, that perhaps the women suffer more than the men do (it is a patriarchal society). There is a crying need for establishing, open women's services, groups, training and information without them having to be secretive, ashamed, fearful or stigmatised.

Youth

Perhaps the most emotive findings have been those about the young people in the community. They do not feel listened to or even involved in the decisions about their own futures. *'The teachers are there to impart information not to listen'* and *'Young people need to be listened to more in the Orthodox Jewish community. There should not be denial, Allow their feelings'*

What has been quite shocking even for the researchers, is the frankness with which some respondents said that *'There are teenage girls and boys using drugs like marijuana, cocaine and speed'* This is alarming as it was always thought that the girls in particular of Stamford Hill were totally immune from such terrible things.

In summation, we hope and pray that this report will open the eyes of those who are the decision makers in the OJC and commissioners in the statutory services, as in the wider world some communities *do* have the openness and social skills to navigate the hospital wards and services. But, in our community due to all of the issues discussed in this report, by the time many parents and families recognise the severity of the problem it is sadly often - too late.

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2. INTRODUCTION

2.1 BACKGROUND INFORMATION ABOUT THE NATIONAL PROJECT

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 (DOH) 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.

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.

2.2 THE KEY INGREDIENTS OF THE MODEL

It is important that the host community organisation is able to co-ordinate the work, and provide an infrastructure (e.g. drop-in centre or office; 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.

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.

The accredited workshops give participants in the project a chance to gain a University qualification whilst they undertake the work. The support workers will also assist the group to form an appropriate steering group to support the project¹.

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

2.3 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.

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3. THE CONTEXT

3.1 Brief history

Stamford Hill, in North East London, bordering on South Tottenham is the “Chareidi Heartland” of Europe, and is sometimes referred to as “The square mile of Piety” although it is in fact about 2 square miles in size. The Chareidi or Orthodox Jewish Community (OJC) of Stamford Hill as it is today with over 20,000 residents, arrived on these shores from all over the world and for different reasons, but mostly during the 20th century as a direct result of persecution, war and genocide. Most of the Stamford Hill community comes from Holocaust backgrounds (about 70%) and they are the survivors, their children and their children’s children, bringing with them their memories, fears and mistrust of the “outside world.”

The Union of Orthodox Hebrew Congregations (The “Union”) was established in 1926, as the community’s movement from the East End to Stamford Hill in the 1930’s and 40’s increased with the many Jewish survivors of World War II. They wished to leave behind them the continents of the Nazis and Communists (Hungarian Uprising, escaping the 1956 Soviet invasion). There is also a sizeable minority that has been in the UK for generations as well as many whose backgrounds range from India, Aden to Morocco.

Stamford Hill is now home to the third largest Chasidic population in the world after Israel and New York and makes more than 10% of the local population. There are a wide number of different groupings or sects within the community. Ten years ago the average family size was 8 children, today that has decreased to 5.9 children, still almost 2.5 times the average for England and Wales.

A Reuters report (1.10.05) describing the community’s new plan of possible movement to Milton Keynes, emphasised how ‘acute’ the housing difficulty was, with the community growing at a rate of ‘eight percent’, ‘many living in overcrowded houses’ and set to double in size in 10 years time. There is limited scope for purchase, and many young couples cannot afford the expense. Dietary observance ensures a large number of established shops although due to the community’s phenomenal growth, ‘Some areas may have room for housing but not for the schools, the synagogues and the kosher shops.’

The OJ community is ‘very poor,’ with paid employment predominantly in the (primary/secondary) education sector. 58% of households below retirement age receive state or housing benefit, with ¼ men and ½ women earning less than £7,500 a year. These economic pressures on the one hand, although expected to produce high levels of emotional and behavioural disorders, are moderated by support systems and cohesion on the other. ‘This degree of cohesion...might offset the risk factors for psychological disturbance’ (Loewenthal, 2000). Statistics in this report prove how the emotional welfare of the community is balanced by a unique and insular support structure; 80% of respondents see their families and 60% meet friends weekly. Stigmatisation and denial regarding emotional disorders lead to less easily accessible information about psychological disturbance.

According to Loewenthal’s report, the community’s school system produces boys without qualifications, though 12% become Rabbis. Indeed there is an emphasis on contemplation and study in the 40 plus schools that cater for the Chasidic community. Education, in addition to deference to Rabbinic authority, and supporting the needy, is viewed as ‘crucially important’, and these values seem to be reflected in the extremely low crime rate and the eschewal of ‘many of the trappings of modern life.’ Local Parent Ratings also reflected less disturbance than did Parent Ratings in a national scale, yet special educational needs, and provision is an important issue.

Despite all of the historical events and resulting familial issues that have been passed down through the generations, within the culture in the OJC there is much to be thankful for, there are many positive effects and outcomes to living in such a small and insular community. The youth although having similar adolescent issues to their peers in the wider world, do not participate in gun or knife culture. There are no single mothers (except divorcees) and the level of school truancy is about 0.06% (compared to the national figure of 8-9%). Most community members spend much of their spare time in doing “good deeds” and helping others and as they all have the same religious and traditional outlook they encourage and support each other when times are hard, so in theory no-one is left in an isolated place within the community.

3.2 Background information to demography of Stamford Hill

According to Holman & Holman in 2002 the OJ population was approximately 20,000, (although it could be greater as many OJs are still fearful of putting “Jew” on any official papers as they remember how such figures were mis-used by the Nazis). This figure can be verified by the fact there are about 3,600 families in the OJC (synagogue membership) and the average family size is 5.9 (Loewenthal), which equals about

21,250. Within the OJC the ethnic mix is about 70% Ashkenazi (those of European descent) and 30% Sephardi (those of Oriental descent). Of the spoken languages, nearly everyone understands English but the Lingua Franca is Yiddish (Colloquial Hungarian) and many speak Hebrew. The Sephardi communities also speak French, Arabic and some Indian dialects.

Many of the men in full time Rabbinical colleges severely lack literacy and numeracy skills as it is generally not taught in their schools.

(For further details, see Appendix 1, Background Information to Demography of Stamford Hill)

3.3 Fears , stigma and denial

The Stamford Hill OJC is unique among other OJCs of Europe, compared to Antwerp and Paris for example, in that it not only lives in an insular manner, but it also lives within the confines of the English “Understatement.” This ideally suits the religious demeanour and almost plays into a victim culture of keeping ones head below the parapet at all times.

It is a well-recognised fact that the effects of trauma can stay in the mind, submerged for a long time, and then when least expected, arise to the surface and give its owner flash backs and relived experiences. If one grows up with a father who screams every night, or a mother who will throw nothing away for over 60 years, “Just in case” then developing into an adult free from emotional baggage can be very difficult. Facing those fears has never been encouraged, “Pray, have lots of children, work hard and it will all go away” but until recently the old habits, fears and behaviours were simply passed onto the next generation without having been addressed or resolved. This is the case for many individuals, families and the community per se.

The first commandment in the Bible is “Go forth and multiply”. In the OJC this equates to “Marry off the children who will then go forth and multiply.” So it is every parent’s duty to teach their child a profession, so that the child can learn to stand on its own two feet and independently make his/her way in the world, thus enabling them to marry someone who is learned and good. If therefore one of the children has less than desirable behaviour, and its common knowledge, then this will create difficulties for the family when it comes to marrying off his/her siblings. The parents would be considered to be not coping well, out of control or simply not the best family into which to marry the precious prince or princess.

Admitting failure to self, let alone another is not a common occurrence in the community, owning up to not being able to cope with the increasing stresses of life is very unusual as it is far easier to sublimate the issues, in case others might cast aspersions. Do anything unusual and you may be labelled “Mad” and *that* might be catching!

If no problems can be seen or detected, quid pro quo, there are no problems. If there are no problems, why would there need to be services or information? “Denial is a way of life, sweep it under the carpet and it will all be OK” was quoted by one of our community respondents.

The world famous, Rabbi Dr Abraham Twersky who founded the Gateway Centre in Philadelphia, USA for substance abusers has often been heard to say “The community (Stamford Hill) is on the banks of denial, and that’s not the river.” In the Orthodox Jewish world, it is a well known fact, that Stamford Hill in particular among all the Chassidic communities of the globe, has it’s own life style and *modus vivendi*, often likened to the ostriches with their heads in the sand.

3.4 Aims and objectives of this study and statement

The objectives of the programme were to deliver, improve equality of access, experience and outcomes for Orthodox Jewish mental health service users by:

Aims

- Being able to identify gaps in preventative mental health services to our community
- Producing a professional piece of work which will have lasting outcomes
- Enabling the OJC to be party to local mental health service planning and provision which is culturally, ethnically and religiously tailored to their needs as a Minority Ethnic Community
- Ensuring greater community participation in, and ownership of, mental health services
- Building capacity in the voluntary sector
- Developing a better understanding by the statutory sector of the innovative approaches that are used in the non-statutory sector
- Encouraging local populations to influence the way services are planned and delivered

Objectives

- Encouraging the OJC to implicitly feel part of the process
- Involving minority ethnic communities in identifying needs and in the design and delivery of more appropriate, effective and responsive services
- Supporting the OJC to gain better insight in to how statutory services are commissioned
- Encouraging the engagement of minority ethnic communities in the commissioning process
- Building their own capacities as individuals, family members and as community members thus strengthening the OJC as a whole from within.

3.5 Statement

The views expressed in this report are those of the group that undertook the work for TMA and the community members who were interviewed in the context of the research, and are not necessarily those of the Centre for Ethnicity and Health at the University of Central Lancashire or TMA.

3.6 The focus of the study

Since 2000 over 200-community groups have taken part in one or other of the Centre for Ethnicity and Health's Community Engagement Programmes, which was backed by NIMHE (National Institute for Mental Health England) through the Community Engagement programme.

2006-7, Talking Matters participated in the second round of the programme where the focus was on Delivering Race Equality in Mental Health. There were 29 groups involved nationally, 5 in NE London and 2 in Hackney, of which Talking Matters was one. It was the only Orthodox Jewish organisation in this round (mental health) in the country to participate. From the Talking Matters' perspective, the focus of this piece of work has been two fold

1. To un-pick the myriads of beliefs and attitudes to mental health and illness from within the Orthodox Jewish Community of North London and
2. To discover the level of care & types of service provision from mental health service provider's and to learn about their opinion of the services they provide in relation to the OJC.

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4. METHODOLOGY AND TIMETABLE

Prior to commencing the Community Engagement Programme, it was vitally necessary to establish what the expressed mental health needs of the service users were and are, in order to be able to establish the most advantageous approach. We called several meetings of service users and counsellors/therapists and worked out what we wanted from such a piece of research and roughly how we might approach the whole project, prior to putting in the grant application. During the project which has taken more than a year, TMA and the research team have kept strictly to our own timetable as well as the deadlines set by UCLAN.

(See Appendix 2, Project Methodology and Timetable)

4.1 Making the application and interview process

When TMA first looked at the application form, it felt for some as if it were the answer to our dreams.

“How to establish the level of emotional need in the Orthodox Jewish Community of Stamford Hill,” from a community perspective. Everyone in the community knew there were “needs” but all research until now had been done for academic purposes and not for creating change. This project through the Community Engagement Programme, could change that, so it was decided to be positive and submit an application.

Compared to many other application forms, the UCLAN form did not appear to be too daunting. What we didn't know at the time was the amount of statistical detail we would have to establish in order to have evidence of need, and eventually how much detail would be required in the process of organising and running a “real” research programme. Nevertheless, we badgered our Race Equality Lead for more information, called several meetings of service users and counsellors/therapists and worked out what we wanted from such a piece of research and roughly how we might approach the whole project.

While on a visit to South Africa came the message “You have an interview next week for the research programme”. The actual team that went for interview was made up of the project manager, a counsellor and a service user. Among the presentations and questions at interview, we asked if our dietary requirements would be catered for on the training programme if we were to be successful. We were assured that “Yes” they would be were (See Appendix 4)

4.2 Recruitment of the teams

Initially, we decided to recruit a research project manager from the community and then three different groups of people, steering group, researchers and interviewees. Before TMA even knew if it had been successful or not we held several meetings with prospective steering group members and researchers from the community to discuss issues, commitment, time available, and roles.

(See Appendix 3, Recruitment of the Groups)

In the OJC it is not the norm to go to university, although academic prowess is recognised and honoured. So finding a community member who might have a modicum of research understanding was at first a daunting task because as many as 75% of the community have not had a secular education and certainly not to university standard.

In the previous year TMA had participated in a small research programme about “Mental Health and use of the Internet” and was interviewed by a young research student who lived within walking distance from our premises. As we believe that G-d is in charge of all of our lives, she was interested in working with the Orthodox Jewish Community (she is a secular Jewess) and we were looking for someone to take responsibility for the project. Our joint prayers were answered.

4.3 Training with UCLAN

Initially 7 people signed up for the training, but one by one found various valid reasons why they could not continue (family, work, clients etc) 4 people started, 2 people completed the training and 1 completed the course work and qualification.

4.3.1 Training and support

It was obvious from the start that some of the trainee researchers found the mixed environment quite difficult, (mixed genders and the mix of service users.) Of the two who left early into the training, one participant

stayed ½ day and the other one, stayed two days. Both looked uncomfortable during the training (the body language and continual fidgeting.) The two remaining participants gained a lot of information from the training in technique, methodology, considerations to be made, ethical issues and format, as well as fully contributing to the training group as a whole. The group mix was very interesting from various points, everyone's backgrounds, experiences as service users, lack of support in the communities, difficulty in accessing support from the providers, the long lasting effects of medication, attitudes of others and the all pervading issue of "stigma." There was much to discuss and learn.

The training manuals were full of very useful information, one for every student built up each week and the sessions were not difficult to understand, although at times it felt like too much information to pack in, and not enough time to discuss and digest. More time in small, interactive groups might have helped.

The venue was not easy to get to (as Hackney is not on the London Underground system) but relatively central. However, the request for Kosher refreshments was never really honoured well and developed into an "issue" *

(See Appendix 4, Kosher Catering)

4.4 Formulating the questions

Many meetings were held discussing what kind of questions would be need to be included in order to extract the information we were looking for; how to phrase the questions; how to make the questions open ended; to encourage probing and in-depth answers rather than "Yes / No" answers etc. At first there were 3 questionnaires;

Questionnaire A - Service users – Quantitative
Questionnaire B - Service users – Qualitative
Questionnaire C – Service Providers
Core questions

After submitting the draft questionnaires to the UCLAN Ethics committee their recommendations were to omit Q.A containing the quantitative questions and to concentrate on Q.B with the qualitative methodology. This was agreed upon and complied with so we ended up with

Questionnaire A - Service users – Qualitative, semi-structured
Questionnaire B - Service Providers – Quantitative & qualitative, both yes/no questions & open ended
Core questions

(See Appendix 5, Questionnaires A and B)

4.5 Rabbinical approval

At the point when all the questions were formulated, one of the researchers took them to the head Rabbi of Stamford Hill (the Rov) who gave his Blessing on the work. Without his Blessing verbal or written we would not have been able to precede with the research and still live meaningfully in the community.

4.6 Test run

Using the combination of Q.A and Q.B a test-run was done whilst waiting for Ethical approval. This gave us a distinct advantage as by the time we did get ethical approval, we had already done the "Test run", had some idea of what worked & what didn't, and how we could change some of the questions to fit better and tighter according to our needs. One of the outcomes from the test-run was that one particular interviewee was really upset about one question asking "What did they (the respondents) think the Rabbis thought about mental health issues?". The interviewee was in fact very upset, almost "out raged" at the question! Why would we be even questioning the Rabbis (community leaders?). Nevertheless after much discussion it was agreed to modify the questions in order not to outrage any community member where possible. It was felt to be a matter of semantics.

4.7 Ethical approval

Whilst waiting for approval from the ethics committee of UCLAN we received a message that we would also require ethical approval from the PCT as we wished to

- a) Involve them as steering group members and
- b) Interview some of them as service providers.

Although we did not think we should need ethical approval, as we were talking to office managers and not staff at the front line in the wards, we were still instructed to get approval. This was far more convoluted than had been imagined. Questions that arose included;

1. Is there a named person to whom one goes for ethical approval?
2. Is there one person for the PCT and another for the ELCMHT
3. Is there one person for both ?
4. What title does the person have, Director, Chairman?
5. Is this person a paid employee or a member of the public with a titular role?
6. Where would such a person be found in such a large area covered by the MHT and the PCT?

What we did find is that no-one in the PCT knew, and if they did have an idea, they didn't know where this person would be located either within the structure of the PCT or geographically. It took many days finding the right person to ask and then many more days to get approval, after which we were told that actually we didn't need it! What we also discovered is that we were given 2 different names, versions and conflicting information. The answers were as follows;

- a. Dr Keith Meadows, Development Manager, NE Sector (NELCRAD), Tower Hamlets Mental Health Trust and
- b. Dr Arthur Tucker, Chairman (Ms Sandra Burke, Co-ordinator) East London and City Research Ethics Committee, Aneurhan Bevan House. Aldgate, London E1

4.8 The process

Part of the process in getting ethical approval included issues on the following;

- What methods we would employ and whether we would use questionnaires, focus groups, semi-structured interviews etc.
- How we would record any interviews (e.g. taped, made notes etc)
- How we would safe guard all information, confidential or not, and what secure measures there would be
- How we would analyse the findings from the questionnaires, interviews, focus groups etc.

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5. FINDINGS: Thematic analysis

The project was divided into 3 sections as follows;

- 4.1 Core questions (See Appendix 6, Core Questions)
- 4.2 Service users
- 4.3 Service providers

Each section was divided into relevant and related issues as follows, and subdivided again into more detailed sections;

5.1 Core questions

The information from 24 interviewees was collected. It should be noted that some interviewees had difficulty in completing the document, perhaps more help could have been offered. The questions on ethnicity and citizenship seemed to have confused several people, as well as the definition of “disability”.

Both researchers and interviewees found this question very difficult, as it is not the norm to discuss such issues especially with strangers or in public. Some researchers thus asked the interviewees if they were married, assumed their sexual orientations on the basis of their response. E.g. married people could be assumed to be heterosexual.

Most participants were between the ages of 50 to 59 (50%), some were between 40 to 49 (20%) and another fifth of the participants were from the younger age group of 19 to 24 years old. 80% were female and 20% were male. 80% defined themselves as ‘other white’ rather than British, those it was an even split of 50% and 50% for participants born on not born in the UK. 65% were British citizens and 60% were English speakers as a first language.

Figure 1: CORE Figures in % (2006-7)

Figure 1.1: Age

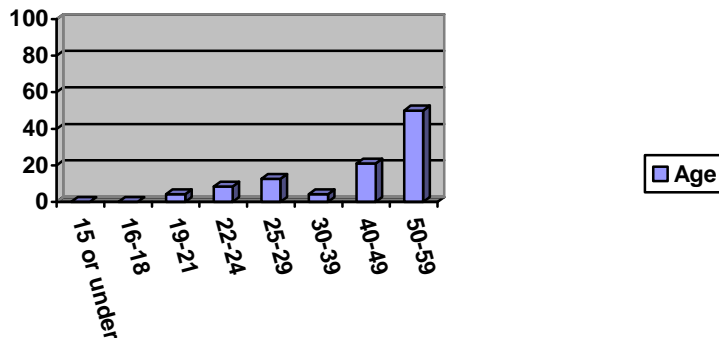


Figure 1.2: Gender

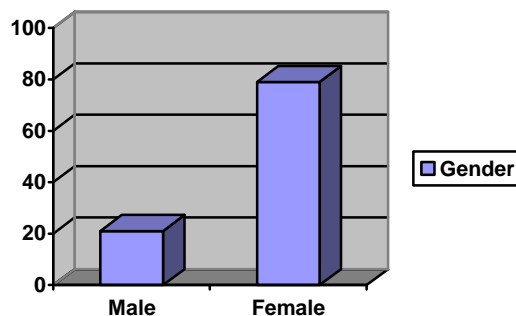


Figure 1.3: Ethnicity

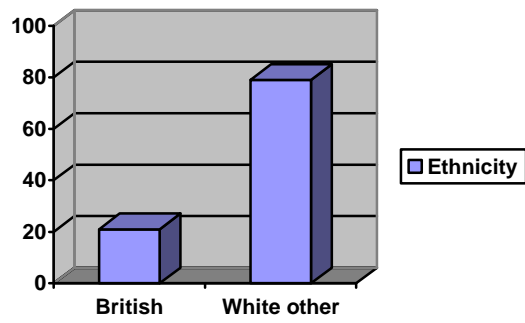
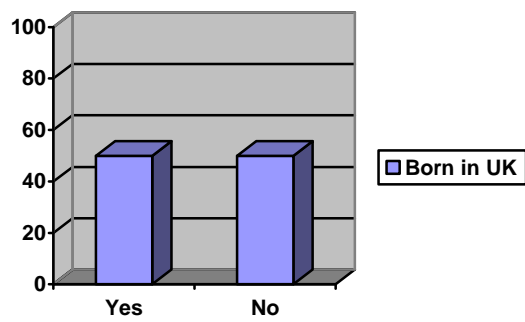


Figure 1.4.1: Born in UK



1.4.2. how long lived in the UK if not born there?

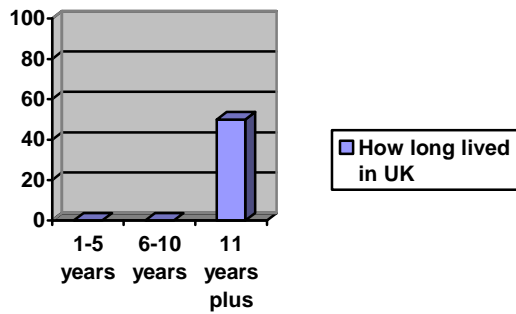


Figure 1.5: Citizenship.

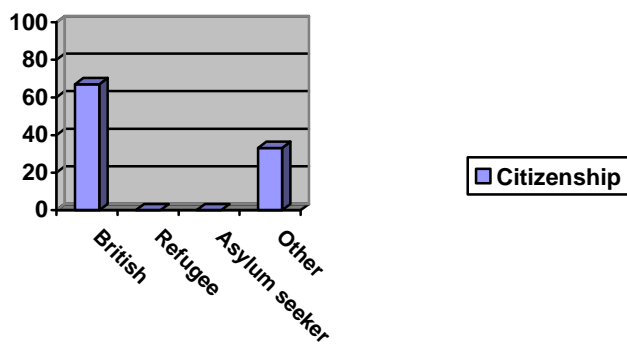


Figure 1.6: First language spoken

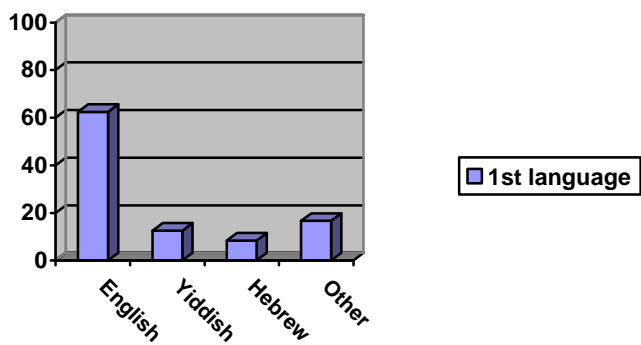
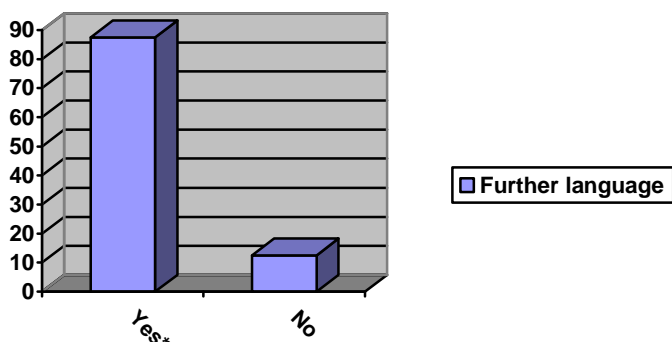


Figure 1.7: Fluent in further languages



Yes* Some recorded English as their second language, for the majority it was Yiddish and/or Hebrew, for some it was other European languages

Figure 1.8: Religion

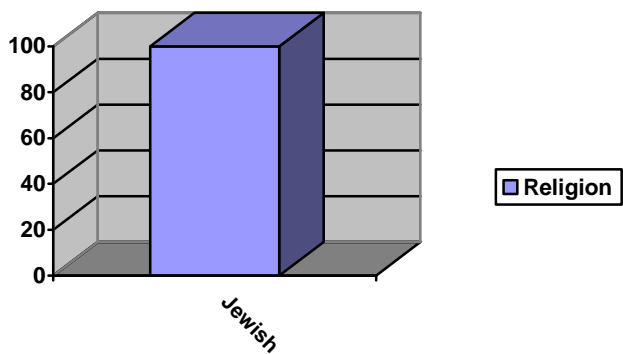


Figure 1.9: Sexuality

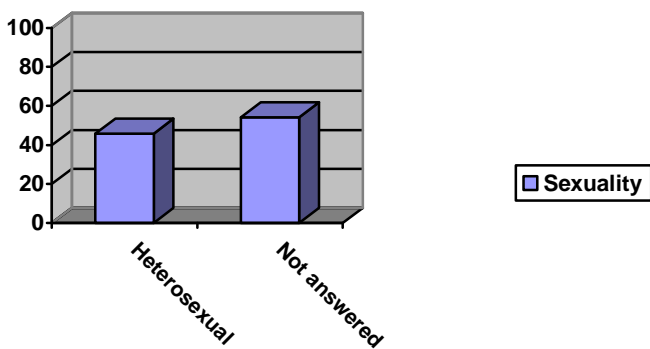
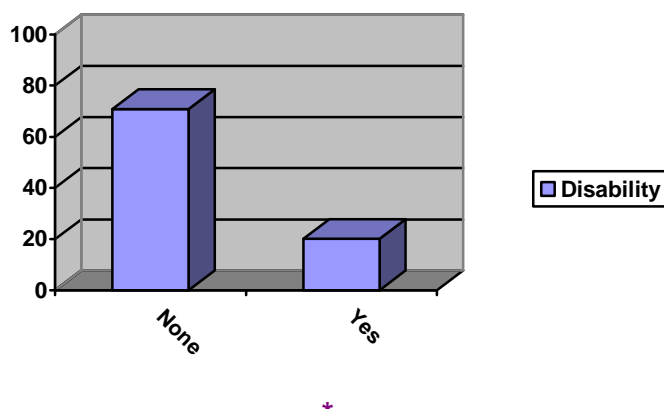


Figure 1.10: Disability



5.2 SERVICE USERS - MAIN THEMES

The overall themes from the service users regarding, service provision and mental health in this research project can be seen as in the following:

	1	2	3	4	5	6	7	8
Issue	Diagnosis	Torah	Understanding of MH in the OJC	Service take up	Women	Youth	Other emerging issues	Participants' recommendations
<i>Beliefs</i>	Fears	What the Torah says about being OJ with MH issues ?	Fear, stigma & denial	OJ versus secular	Male and females roles in the OJC	Young people's role in the OJC	Taboo subjects	Need for education
<i>Attitudes</i>	Stigma	Rabbis & Rebbitsens;, their roles and influence	Social issues	Perceptions of mental health.	Stigma in the OJC re women not coping	Youth culture not understood	Stigma	Improvement to services
<i>Behaviours</i>	Denial – No care plan	The Torah & wellbeing	Social issues derived from beliefs	Community support	Denial re; divorce, difficult children	Suppression versus support	Denial re; Unacceptable behaviours	Culturally sensitive services

5.2.1 Diagnoses, Care plans, fear, stigma, denial and judgmentalism

5.2.2 Torah, culture, Rabbis and Rebbitzens*

5.2.3 Understanding of mental health in the OJC

5.2.4 Service take up

5.2.5 Women

5.2.6 Youth

5.2.7 Other emerging issues

5.2.8 Participants' recommendations

(See Appendix 6, Figure 2: Overall themes: service users questionnaire)

5.2.1 DIAGNOSIS

Many cases that were discussed included Clinical depression. A hand-full of cases of Schizophrenia were reflected upon, and some individual with suicidal thoughts were reported. Along side the above, aggressiveness, loss of control over emotions, being dishonest, emotionally harming to oneself and others were described. Panic attacks, severe introversion of a few different individuals, difficulties to communicate, escapism from reality and obsessive behaviour about cleanliness were mentioned too. *(Had some of these cases and conditions been reported to statutory service providers, then there might have been an increase in service users reporting increases in self reported states of recovery, DRE, see page 49)*

Post natal depression causing permanent clinical depression, and anger and upset after divorce were two specific female related issues. Psychotic episodes, stress, personality disorder, severe hypochondria and moodiness were noticed and elaborated upon.

Some behavioural difficulties experienced by teenagers were reported for that particular age group.

Explanations of why diagnosis was not made: denial.

“Because in the beginning it was a first time post natal depression and later it was swept under the carpet”. Participant 5.

Participant 5 is talking about a lady who had a post natal depression and eight deliveries. In fact occurrence of the disorder was not recognized and later on it was swept under the carpet, in all cases it was not reported back to the professionals, *ie illustrating the fear of mental health services and stigma and the need for more appropriate and responsive services, as in the DRE priorities (see page 49)*

Other explanations were related to the family, and stress. Of course genetic attribution to mental health exist in the wider population and stress is indeed a cause for many mental health problems.

Care plans

Many participants reported that the people they talked about did not have a care plan. This included severe cases such as schizophrenia and clinical depression. Care plans that did operate were at times an internal care plans drawn by Jewish community mental health organizations like in the case of Participant 21, a Jewish female teenager who was resident in a Jewish foster home. *(If care plans were instituted across the spectrum of service users then perhaps there would be “increased satisfaction with services” DRE Priorities see page 49)*

In the case of Participant 23, a care plan was implemented well over the years, but there was no aftercare,

“The advantages of after care are to build on therapy sessions.” Participant 23.

The reasons for not having a care plan were diverse. For example:

“No care plan can be made because he doesn’t engage with those trying to help him” Participant 24.

The issue of having a care plan or not is connected to service uptake, as it is provided by non- Jewish professionals. Please see section 4.2.5 for further details.

Fear, stigma, denial and judgmentalism

One has to investigate and understand the social processes involved in the religious beliefs and feelings of individuals in order to take account of the social interaction of structured groups, such as the Orthodox Jewish Community. (OJC) A key feature of religion is the religious group. Like other social groups, religious groups have explicit and implicit functions, leaders and members who have special roles, norms and standards. Loewenthal (2000).

One of the most interesting sets of questions in the psychology of religion is whether religion fosters feelings of guilt, shame and obsessions, arising from anxiety over the need to be careful in maintaining religious rules

(Loewenthal, 2000). Although we did not attempt to solve this important debate our findings have indeed brought to light many responses and quotes regarding guilt and feelings of shame.

“Didn’t tell anyone because felt shame”, Participant 23

“If community found out about breakdown, then the person would be “black” listed and the person would feel embarrassed and ashamed”, Participant 20

“I think she is ashamed of her own problem, I do not think she is denying it to herself”.

As reflected in the above quote, the woman concerned is thought to be feeling ashamed of her problem. The participant attributed self responsibility to the service user for having that mental health issue, and possibly because the woman who is discussed suffered from post natal depression, and being depressed contradicts the mitzvah (religious obligation) to be happy. This might explain the shame, however, the emphasis is upon the feeling of shame itself and not the causes for such feeling. Shame is caused by prevalent stigma in the community.

Fear (or anxiety) is a common emotion, and has to be distinguished from the psychopathology. It is an ‘unpleasant emotional state’. It is an ‘anticipation of future evil’ (Loewenthal, 2000). Participant 5 elaborated upon the issue of fear which was felt by a depressed woman:

“I think if a person has been through a hard time, of not having full control of your mind, you’re very fearful... You’re afraid of the episode being repeated itself, you don’t trust yourself for being stable because of the experience you had, and you’re also afraid of other people’s opinion about you. If you’re not 100% sure about your own image, how do you expect others to be sure about your image, to have a positive attitude, you know, towards you.”, Participant 5, Page 6, line 337.

It is interesting to note the cause and effect of fear: being afraid from the depression reoccurring *and* being afraid of other people’s judgement. This leads into the sub theme of fear and judgement about behaviour within the community.

Stigma, reputation and marriage

People are very concerned about their name and reputation especially in a small closed community, where one constantly meets the same individuals in different circles. If one is about to marry off a child in an organized marriage (a Shidduch), it is essential to ensure that both the bride and groom come to the marriage with equally good a reputation. So due to this key issue within the community, ones behaviour has to be seen to be immaculate at all times.

“People are not allowed to be themselves. You have to behave nicely and kindly at all times, you must not be angry”.
Participant 7.

If one’s behaviour is not seen to be 100%, especially for the young, judgmentalism sets in. The prevalence of stigma in the community is maintained due to several things including behaviour, mental health and most notably organised marriages. Mental health is a “real” issue. The words “Real” and “Issue” have been repeated twice, as if emphasising that even though mental health is in the spiritual domain, it is still a very substantial issue.

“One’s actions have implications for his family, Guilt for loss of status of your family occurs” Participant 19.

In the Torah world of the Orthodox Jew, gossip is forbidden. Participant 26 relates the close proximity of living conditions to the prevalence of stigma. Gossiping keeps stigma alive as its a common social norm, maintaining a certain level of information and awareness or often dis-information and untruths.

Stigma and secrets

People in the community will not tell anyone about their (emotional) illnesses. The manner in which they will hide mental health conditions as a result of the fear of stigma is reflected in the following example:

“He told no one, did not discuss emotional problems even with his wife”. Participant 17

The secretive issue was reflected many times, (See Appendix, Participant 20 re Stigma)

Ignorance and the need for education

Some of the interviewee's opinions on issues relating to stigma are not as well informed as compared to the "wider community", such as,

"Mental illness might be catching"
"Stay away from someone who is mentally ill"

and that the community gets scared of anything out of the ordinary and responds with

"We do not want to hear anything more about it".

Many participants spoke about the need for education, and for psychologists or counsellors to visit the local Jewish schools and explain about mental health.

"We need educational psychologists and social workers to be part time available in schools and to educate headmasters about emotional problems", participant 15.

Stigma and not conforming to religious requirements.

Participant 19, mentioned that because Stamford Hill is a small community providing all the functions in one's life, people are reliant on the community for self worth. Every body knows everybody's business and watch whether they conform to religious and cultural norms or not. A negative reputation and stigma are created by not conforming to religious and cultural norms. We heard the same observation in regards to a young girl who was not conforming to religious norms. (Please see Young people section).

The relationship between the spiritual and the physical is an interesting one. There is a dichotomy of spirit and body reflected in the Jewish way of life in Stamford Hill. People are describing mental ill health as a physical ailment. By addressing it in this way it made more sense to describe the mental problem through the physical manifestation and possibly made it less strange or threatening.

"The family told people she had the flu. They told people she had pneumonia". Participant xx

This is an extremely interesting quote, because both what occurs is the comparison to having a concrete illness, the flu and/or pneumonia, but also the fact that they used this as a way to hide and deny the real issues.

Regarding marriage, Participants 20 and 16 talk about how if there are mental health issues in the family this will affect the marriage prospects of the children. If the community finds out about break down than the person will be shunned...this is a very interesting quote the image being very strong. This is also reflected in Participant 23, who "Did not tell anyone because of feeling shame". The whole issue of the fear of what others will say, and the personal guilt about being unhappy, as the Torah commands us to "Be happy". Questions arise for the individual as well as the family, as the obligation of any Jew cannot be upheld leading to the question "What is my role in this shameful illness?" and "What shall I do about my not feeling happy?"

Counselling services are often not taken up because the problem is swept under the carpet. It is quite hard to differentiate between denial and shame

As a direct result of ignorance, stigma, being "Labelled" resulting in being shunned within the community will cause added stress on top of the illness.

"Mental illness will deter marriage" Participant 9.

"People are not scared of the disorder as much as they are afraid of the social reaction"

This is a very important quote as it describes the judgmentalism and how people are watching one's behaviour. People are so worried of others judging and blaming them. When mental illness does appear, families send children away from home, denying that there is a problem, and tying into the whole issue of secretiveness and denial. People do not tell about their problems as the perceptions are that mental illness is catching – or contaminating!

5.2.2 TORAH, CULTURE, RABBIS AND REBBITZENS

How the respondents perceived the Torah's approach to emotional and mental health issues: Two distinctions need to be drawn to give some shape and meaning to the responses in this section.

Firstly, some answers focused on the Torah per se while a minority dwelt on their impression of the values espoused by the Stamford Hill O.J.C. Although the reader may be surprised, these two need not be exactly the same at all times. The ideal standards of behaviour which the Torah sets are not always consistently achieved or precisely reproduced in situations where human frailties and social mechanisms that develop in a community come into play. And, just as every class in the same school has its own personality, for example, so one must bear in mind that each O.J. community develops its own characteristics and imperatives.

One respondent, for instance, felt that the O.J.C. has no commonly held beliefs at all about emotional problems, a second that there are beliefs (unspecified), but these suffocate spiritual problems, and a third that the social norm in Stamford Hill is to sweep problems under the carpet.

When we turn to how the Torah's position was perceived, we need to draw our second distinction between the respondents (group A) who saw the Torah as commandments which the emotionally ill person cannot live up to, and a larger number (group B) who saw it as a source of help or succour.

Group A: When one is ill, rituals are hard to perform; one cannot be Orthodox if one has special emotional needs; to be unhappy is a sin; the light no longer shines on someone who is mentally ill.

Group B: As with all health problems, the Torah tells us to seek treatment. The Torah acknowledges depression and sees joy as a key to healing for all health problems. Prayer on behalf of oneself or others and caring for others help wonderfully and, in return, bring on Divine assistance. Belief in G-d allows one to ride above many negative situations and people. The Torah emphasises the positive and sees difficulties as opportunities for growth.

Torah and Mental Health: Positive elements.

'Torah and Judaism have a positive attitude to mental health' explains Participant 9.

The Torah is seen as a source of healing, with insights into well being.

"The enormous amount of examples of physical and emotional help that individuals found in the Torah help people with mental health issues to cope with their own struggles". Participant 9.

Participant 7 described the Torah regarding mental health with an outlook of trust- 'G-d is there' that people under stress 'keep the wheel' as there is a basic message that has to be 'worked out'. This attitude of understanding purpose within illness, with the 'transcendental element' is thought of as an '-added bonus' Participant 9 concludes that 'any faith brings meaning'.

What the Torah says about being OJ with MH issues?

A person's behaviour depends on their attitudes which are founded on their beliefs. Belief is the cognitive aspect of religion (Loewenthal 2000). The term religious belief will be used here to refer to the content of beliefs about religious matters – what the individual and the community believes about G-d, the commandments and spirituality.

Madness is mentioned in the ancient Jewish texts without clear attribution of its cause, though there is some suggestions of a distinction between spirit possessions and insanity. Later Jewish sources of the Talmudic period distinguish a range of psychiatric conditions resembling those found in contemporary practice, and there are well documented accounts of Chassidic Rebbes* (the spiritual leaders) who had major bouts of depression (and possibly Bi-polar condition) (Loewenthal, 2000).

In Jewish law, the legal status of the insane with regard to their civil and religious obligations is not a matter for discussion in this study, however issues relating to participants' beliefs and attitudes to mental health are very pertinent to the core of this work. For example, whether the insane are valid witnesses and whether insanity is grounds for divorce, are matters for discussion in a court of Jewish law and not this report. However, the Hebrew term for madness (Choleh Nefesh) means sickness of the soul, and there are Rabbis in many Jewish communities world wide who carry out pastoral counselling based on commonly held views

that the rectification of spiritual or moral failings – such as pride – will improve mental health. Misfortune is seen to be as a warning to the individual to improve, and as a divine test of the individual.

This indeed was found in the current research. There was one participant who had a schizophrenic son and a daughter with emotional issues, who said “It was a test “(from G-d)

“The Family learn from the experience – it made us stronger people” Participant 11

“Everyday I pray to Hashem to help me keep my head above water, my daughter told me “Look mum, we are such a strong family, we face the challenges and not just sit around, it is a test”, Participant 18*

It is also generally believed in the OJC that as part of an overall divine plan in which everything is for the ultimate good, misfortune is seen in Jewish mystical thought as part of the process of life and after life, involving reincarnation, in which the errors of previous incarnations are repaid. Through the repair process Messianic completion will be achieved (Loewenthal, 1995).

Consulting the community leaders, Rabbis and Rebbitzens *

From the dawn of the Jewish people there has been a tradition to consult Torah scholars, whether they hold official communal posts (e.g. Rabbi of the local synagogue) or not, about both questions of Torah law and life issues. Many women might consult a learned Jewish lady or Rebbitzin. In recent times however, especially in a Chassidic community such as Stamford Hill, many people will go higher up the ladder to one of the Sages of the generation for very personal or life shaking issues or – increasingly – to professionals in the relevant fields.

Regarding the community leaders and Rabbis, the respondents fall into three classes: those who see them as,

- 1) Helpful and positive;
- 2) Not equipped to deal with emotional problems and even antithetical to the whole process;
- 3) Having strengths that lie elsewhere – these respondents do not go to the Rabbis regarding emotional health. If they did, they would expect the Rabbis to refer them onwards. *(However if the Rabbis and community leaders were made more aware of services available and a more balanced range of effective therapies, they might be more willing to refer more readily and more often, as in DRE priorities, see page 49)*

Group 1: A small number of respondents felt that the rabbis are doing the best they can, and would be supportive if consulted.

Group 2: They are judgmental, narrow-minded and don't want to face up to certain types of problems. They're not trained, don't offer effective help and may respond inappropriately (e.g. sending up the whole problem). They stay within communal norms but follow their own likes and dislikes. They resent those who go outside the communal framework for help, because it breeds independent thinking, which may challenge their authority.

They look down on you and the best they can offer is, “Follow the Torah and all will be well.” Their primary concern for the individual is that he lives a religious life, not that he be happy.

Group 3: Mental and emotional health is not their area of expertise. We would go elsewhere to someone who can help and we would expect them to direct us towards proper medical assistance.

The Torah & well-being

Perception in the community if one is mentally ill, one cannot do what the Torah wants one to do:

“The Torah wants us to be happy, if we are not mentally stable we cannot be happy” Participant 9

“When being mentally ill it is not worthy being a Jew” was articulated by a few participants.

Indeed, there was an equation between religiosity and happiness, and the same participant indicated that for him well being means to be happy:

“ The more religious you are the more happy you are, well being means looking after yourself and being organized and in control ”.

While the control aspect of the above quote is in line with current theories of well being the religious devotion is unique to believing individuals.

5.2.3 UNDERSTANDING OF MENTAL HEALTH IN THE OJC

This section will attempt to understand the experience of mental health in the OJC.

The theory of why emotional problems happen ranged from “They happen after emotional trauma” to “Emotional trauma, if not acknowledged has detrimental effect”. Indeed from other sections of our questionnaire we have learnt that emotional problems are often left unacknowledged because of fear and stigma (*Please see previous section ‘Stigma’*. This also fits exactly into the DRE priorities of better information. If the community had more understanding of the issues and effective services which are culturally appropriate then more of the community would use the services, see page 49).

“Personal nature and an event such as death can cause depression” – is not the perception of a strictly Jewish audience. Likewise, one participant asserted:

“The way children are raised by parents can cause mental problems, if parents are not around, children get damaged.”

The understanding that children – parent’s relationship is a cause for mental health issues is not unique to members of the OJ community. This was rooted in the theories of the founding fathers of psychoanalytic psychotherapy (Freud, Jung et al.) However, saying that if the parents are not around – emotional problems will occur and emphasizing the amount of time children are exposed to their parents as a necessity for well being – was the emphasis of our participant. This highlights the particular understanding of mental health in the community.

Explanations of mental illness causes were attributed to the physical. For example, Participant 17 said:

“Fortunately for me, I had something that was physical so it could be treated”.

This suggests that something that is medical can be treated, but something that is not medical, that is in the domain of the spirit and the mental domain is a much less fortunate situation. Explaining mental health as a lack of awareness of G-d’s presence is an explanation rooted in the belief system of the participants. It is believed in the OJ community that lack of awareness of G-d may lead to mental health problems.

“Lack of awareness to G-d’s presence..”

Participant 9.

Conversely, when one is not aware – he/she needs to be made aware by praying more (Davening), and that indeed is something that was told repeatedly by our participants, people were told to daven more to heal their mental health.

Equalizing generalization – “Everybody has got a problem”. That is a way not only to explain mental health problem but perhaps also as a way to reframe the problem and make an individual problem as of a group thing, ‘Many people have a problem’ means that the problem of the many people might be seen as less of a big problem for the individual.

High expectation for men to be a “Talmid Chacham” (lit. Wise or clever student (in religious studies.) This fact was emphasized participant 8. He came from a family with a mother with high expectations. A similar case study is reported by Loewenthal (2000). Apparently such high expectations can cause stress, anxiety and a variety of emotional problems. The attempt to achieve these high expectations in the case of a gap between reality and the aspiring parents can be a difficult emotional experience. Issues of self worth may arise and were reported.

“His mother and father expected him to be talmid chacham, now he is an introvert and avoids people. ...He does nto share with me, his wife, his thoughts” Participant 8..

Changing attitudes to Mental Health in the OJC

The dissemination of information for example the Rabbi Twersky’s books, said participant 9, help alter attitudes within the community. The ‘hiding away in the cupboard’ approach of 15-20 years ago by

misinformed people has progressed so that 'people are more understanding that it is an illness you can manage' P9. The phenomenon of sending people away for better treatment is changing.

The Jewish therapy support groups have proven helpful in 'breaking down the barriers' P9, and create a pathway for recreational development to aid the emotional e.g. occupational therapy to help with social issues.

Statutory services are interested in improvement, but are stretched with 'resources' is claimed by Participant 9, and also by Participant 12. They think that non-Jewish services indeed show progress in terms of treating the OJ community. For example,

"One 'step in the right direction' is the provision of a women's ward". Participant 1.

This is also reflected in the need to provide a more balanced range of therapies which are acceptable to the community, which have professionals from within the community providing the services and which are not seen as providing "stretched resources" (See page 49 for DRE priorities)

The need for more resources and 'wider reach' was stressed by Participant 2. Participant 3 did not rate how satisfactory services are to the OJC because...

" It is 'more complex' than that".

A combination of strategies can be employed. Participant 2 expressed a need for more accessibility to services:

*"Improvements in accessibility is a high priority...
the more accessible the better, for example: 24 hour service"*

This again amplifies the need better equality of access as per the DRE priorities on page 49.

Wellbeing and community norms

The demands of cultural norms that exist within the community can interfere with emotional well being. There are 'specific' and 'unique' demands on both men and women with regard to their social roles – men to be a 'Talmid Chacham' (scholar) and women to be a 'super balebuste' (super housewife). This is in addition to the general peer pressure of family size which can exacerbate stress and create economic hardship. Loewenthal describes the phenomenon of features of cohesion and family support which moderate these pressures. Alcohol is not an escape route which is legitimate for OJ men. They 'do not calm down with whiskey', and therefore there is more depression. Another feature affecting well being is the pressure of the concept of Simcha (the command to be happy) which is a two edge weapon, P7 and can help contribute to denial.

Cultural norms and needs

You have to behave in a certain way. People are not... It is a one way street; there is only one possibility of the right way of behaving. People are not allowed to be themselves, you have to be nice and kind, polite and never be angry. The issue of not being allowed to behave angrily can be seen as oppressive.

"Every thing becomes bottled up"Participant 7, line 270.

*"You have to be on your best behaviour because
you never know whether other people are watching"*

The issue of other people watching is of course very important, because this is the social mechanism of how norms are maintained. One has to always maintain composure, it is about pretence commented participant 7. This might be quite difficult in particular when having mental health issues or can also exacerbate mental health problems.

Participant 9 commented about the belief that one has to belong to some organization. To a social group ... so if you belong to a social group or institution or organization. If that does not suit you, you feel isolated. The norm of belonging to social circles can be felt as a burden.

"When being mentally ill it is not worthy being a Jew"Participant 9.

That is a very strong quote. If you are mentally ill you are not entitled to belong to the group. This means terrible exclusion and isolation for the individual – for their self identity held at previous times of better health.

“We are much more narrow minded, we are not open to the world”..... Participant 8,

It is a normative thing to socialize, because it is a small community with many inter linking parts. At the same time the Torah encourages one to keep a clean home with high hygienic standards. In particular for women the two can contradict each other and create stress. This is what this female participant describes.

“Our education and belief made us obsessed about cleanliness but we are also asked to be hospitable and socialize and the two are hard to combine”. Participant 8

The other social norm is the command to think about other people, and to love other people, (Ve ahavta le reacha kamocho) is the Hebrew saying “...and you loved the other like yourself”, not to be self centred as a Jew). If this is the social norm and the commandment or Mitzva, one might hope that many mentally ill individuals in need will be helped. However, if you are the one with emotional problems you might be inclined to concentrate on your own problems. This can create guilt. Loewenthal (2000) describes the connection between guilt and religiosity. In the cases of the individual failing to fulfil the religious commands this can cause a lot of guilt.

A prominent social issue in the community is arranged marriages (Shiduchim) and mental health labelling. One’s actions have implications to his/her family. If one is mentally ill their chances to marry other ‘good’ families are reduced dramatically, and so are the chances of his/her siblings. There is a reduction in status to the family. This was reported by participant 19, and one cannot emphasize enough the implications of this issue to stigma creation around mental health.

Further issue is the pressure to be financially successful and not being able to go to university, as this is not encouraged by the community. There is a certain prevalence of inadequate secular education and desperate need to provide comfortably to large size families. This was articulated by Participant 19.

“Because the mixing of men and women is frowned upon, you grow up without speaking to the opposite gender. When encountering emotional problems, the issue of sexual practice can also be an escape. This might be with random people or self”..... Participant 19.

The issue of sexuality is not spoken upon nor spelled out to young people, and denial of the need to be aware of it is a common attitude.

Use of drugs and alcohol

The use of recreational drugs is strictly forbidden and alcohol is only used for celebration, so where as in the non-Jewish world having a glass of wine or whiskey at the end of the day is acceptable in order to “wind down” after a hard day at the office, this is not the norm in OJC. Such social pacifiers are only used in or for ‘Simchas.’ This can therefore limit the perceived escape routes for some stressed individuals.

Huge emotional stress can be caused by insolvable identity situation. Participant 19 talks about the issue of identity because once the individual finds it hard to comply to religious norms the options for that individual are extremely narrow. The (ex) orthodox Jew cannot just undress from their black and white Chasidic uniform and join the non Jewish world. They are not equipped to live in the secular world and are left in a great void. This void is a great cause for emotional distress.

Participant 21 reiterates how a marriage of a young rebellious girl might be jeopardized as her actions will reduce the chances of her and her siblings chances for good marriage due to her rebellious behaviour.

5.2.4 SERVICE TAKE UP: ORTHODOX JEWISH VERSUS NON JEWISH PROVISION

Judaism is the basis for both Christianity and Islam with all world religions proclaiming universal brotherly love. Yet, history is littered with long, dark moments when religion has provided a justification for, and has given cause to, all kinds of atrocities directed towards people of different beliefs, race or culture: The Crusades, Slavery, The Holocaust, etc. A considerable number of historians and theologians concluded that religion should contrarily be considered as a catalyst for racism and anti-semitism etc. (Duriez & Hutsebaut, 2000).

The history of this OJC (Please see Introduction) clearly shows why and how they do not trust “outsiders” or those perceived as being in a position to challenge the beliefs, culture or life style. Historically one did not go to an outsider to discuss your problems, unless it was a specialist doctor not otherwise available locally. One went to the Rabbi who would give you his wisdom and sound advice from the Torah. Today the Rabbis’ work schedules are so full that often they are just too busy to take on board those with multiple issues, plus they are no longer equipped to counsel those who may have modern day issues like serious mental health or substance abuse issues. From the perspective of being a community member, accepting counselling and mental health services from outside is seen as admitting to not being able to cope and also going to an outsider who may attempt to change your values, is not the social norm. (*Changing the perceived views about statutory service provision in light of the inherent fears of “outsiders” will take a long time, perhaps even generations as it’s matter of social education and trust, DRE priorities, see page 49*)

This report would like to emphasize a two way relationship: on the one hand the OJ community is indeed an ultra religious society with a strong sense of trust directed inwardly to its own members, and lack of trust to others. On the other hand, ignorance, the lack of understanding about the community and in some cases reluctance to implement change by some service providers plays a significant role too. *This is particularly pertinent regarding a “workforce capable of delivering appropriate and responsive mental health services to this community” in that there are no orthodox Jewish mental health professionals employed in the borough to work specifically with the OJC with whom the community would immediately identify and trust, plus generic employees severely lack the necessary cultural knowledge to provide such services, DRE priorities see page 49*)

Loewenthal (2000) asserts that perhaps one of the greatest paradoxes of the psychology of religion is the fact that, although all religions teach about the brotherhood of man, and all claim to teach respect for fellow humanity, often members of other groups are seen as inferior and not as fully human as those in one’s own group. This is where prejudice is involved. Prejudice is defined here in the sense of derogatory views of the socially unlike: the ‘others’. These ‘others’ are not sympathized, and are seen as holders of a different moral standard.

Adorno et al (1950) identified several prejudices and related traits, such as ethnocentrism, the tendency to political and economical conservatism and anti-Semitism.

Ethnocentrism is defined as in-group loyalty plus distrust and dislike for members of other groups. The great paradox is that there are generally consistent associations between measures of religious behaviour and measures of prejudice. The more religious are generally the more prejudiced. As mentioned in the introduction of this report, there are many historical reasons for the OJ community to distrust the non-Jewish world. This has been reflected in our findings. Participant 18 is a second generation to the Holocaust, a daughter of a survivor with nightmares who believed the war might reoccur:

“My mother had a shock when loosing her family, her parents and all her siblings left from Brussels to Auschwitz and she was left the only member of the family alive. She had terrible migraines and every night woke up...she would cry, and I would also hear my father scream from night mares. They were living in fear...it is only recently that I realised that my mother...it was just one long sad life... was in a total depression since the war till she died my father found lots of matches...she was always afraid there would be another war. Sometimes I get nightmares as though I am in a concentration camp”.
Participant 18.

The above quote illustrates the distrust, the worry, sadness and difficulties that are still prevalent 60 years after World War II.

Using mental health services in general:

Stigma is prevalent and evident in the following quote. Admitting to have a problem that is not well understood is not advisable, better to keep quiet:

“By making use of the facilities you are actually admitting that there is a problem, and you’re involving more people into the problem, you’re publicising it, and in a condition of mental health I think many people try to hide it as much as they can. There’s a stigma about this illness, it’s – it’s frightening, it’s just something which is frightening, it’s something which is not very understood and therefore it’s better to keep it quiet”.
Participant 5

The above quote was given by a grandmother who described her daughter in law suffering from on going post natal depression. This clinical depression started as an undiagnosed incident and went untreated for many years. The depressed lady was a mother of eight children. The participant related the denial of the problem by the husband and the depressed individual herself to the lack of proper care, and under use of mental health services. *(However had, there been Orthodox Jewish services available to deal with her problems she may have come into the system much earlier, thus her experiences would have been far better, DRE see page 49)*

Orthodox Jewish services – positive experiences

Participant 9 commented:

“I had worries because I need someone who will understand our culture”.

Further to that, not respecting things such as the normative dress code can cause break up in communication, as described by the same participant:

“One health professional was unaware of the dress code and was extremely inappropriately dressed... it was a consultant woman and I was horrified...” Participant 26

Participant 15 reflected about the shared value system of an Orthodox Jewish counsellor:

“The structure where a person comes from or wants to be in – if that is broken it compounds the problem, so although the emotional problems will be there for all cases (Jewish or non Jewish therapist) the Jewish therapist can understand that”.....Participant 15

Participant 18 is a mother to a schizophrenic 30 years old man. The family sent him to Israel in order for him to stay within a religious similar context and she reported:

Jewish foster families made patient feel comfortable and moderate improvement in his conditioned has occurred.....Participant 18.

In general, most participants felt that:

“ OJ counsellors can understand an OJ person, woman, man needs and emotional being better”.
Participant 9

All of the above show just how successful and effective culturally appropriate services can be when they get it “right” by offering not only a range of therapies but also in the right setting and with OJ counsellors and therapists who are trusted (DRE priority, see page 49)

Jewish services – negative experiences

Participant 18 articulated a frustration as a result of using an OJ organization that works with the acute mentally ill sector.

“Jewish therapy and care was not successful: I used (name of organization) and the patient (son) used (name of organization) too, but in both cases the service was not successful..., did not seem to enjoy it. Their help was in recommendation to apply for disability benefit allowance”. Participant 18.

Participant 19 was complaining about lack of discreet treatment and said that he was worried that the Jewish therapist might judge him, and tell other people about his issues.

“If you go to a professional from the community...here is a fear, it might stop you from going to an orthodox Jewish (counsellor). You are stuck again! There is a sense of isolation... You are scared that the Orthodox Jewish counsellor will sit in judgment of you. The mode is default Judgment! Critic! Figure out which sect or family you are from...that is why people opt to have no help. In the Heimishe culture there is lack of professionalism”.....Participant 19.*

This Participant, a male individual of 30 years old complained about lack of professionalism in the OJ service for those with severe mental illness, adding to the need for help from non-Jewish sources.

Non Jewish services – positive experiences

Participant 26 reflected on the positive of choice:

*"...on the other hand, people should have the choice to use professional not from the community".
Participant 26*

and Participant 19 saw the positive in discrete treatment:

*"Positive point of non-Jewish counsellor is that you might not be judged,
and things will not go back to community".....Participant 19.*

Non Jewish services – negative experiences

Delay in statutory funding, specifically for women, was reported by Participant 16. She attributed this to the belief (by the service providers) that the OJC can afford to look after itself.

In the case of Participant 24 – It was not known if the psychologist understands cultural & religious needs but, according to this individual: "friends certainly do".

5.2.5 WOMEN

The position of women in the community can be a vulnerable one, in respect that divorce is dependent on the "Beth Din", a group of 3 Rabbis who will review the petition and allow the marriage to end. A divorce will need the approval of the husband, and without his permission or "Get" allowing the dissolution of the marriage, the wife may not be free. Divorce is also perceived as the end result of not being able to cope with life's difficulties and hence, there is a certain stigma against divorced women in the community. According to Jewish law, women cannot make the final decision about divorce, it has to be the man.

Participant 4 was telling a long and sad story about leaving the marital home and 38 years of marriage, with nothing but the clothes in which she stood. She said she was met with little sympathy and now lives in great poverty.

*"He would only give her a divorce if she signed a paper that she didn't want anything
from the house. Now she is struggling very badly because she has no money",
Participant 4,*

*....she went out of the house without nothing, a neighbour knocked on the house, she
took her towel from the landing, she opened the door, she had been standing behind the
door, he told her to bring a key form the house to let her out. Another neighbour came
up the road and she found a pair of shoes in the hall and that is how she left the house.
Maybe the drink or cigarettes, he drank on Shabbas* and that's why he went wild. He
used to lock her in the house [from Friday to Wednesday] if she went out, she couldn't
come back in".
Participant 4,*

The background to this snap shot, of the social help required by local organizations who lack funding to be able to help is also illustrated thus;

*"She once phoned one of the help lines and they told her Monday Tuesday Wednesday
we are closed, whatever she said 'yes but now I'm going to kill myself'. There was
nobody there. You need somebody twenty four hours. What if somebody says they are
going to kill themselves but nobody there and she goes kills herself? Maybe this has
happened I don't know"
Participant 4,*

Because these local small organisations are short of staff and funding many woman such as this participant are 'not receiving help'. (Please see the Recommendations for further details).

A second issue is post natal depression. Another participant discussed her daughter in law who suffered from re occurring clinical depressions. The first one occurred after her first baby was born and went unnoticed. Further reoccurrences of the disorder were not treated due to denial.

5.2.6 YOUTH

The study shows that young people in this strictly religious community are not involved enough in the decisions about their own lives and that their opinions and views are not taken into consideration or supported when they have emotional problems. They need to be listened to and encouraged to express their feelings. There needs to be the provision of better awareness of the issues, by educating members of the community through lectures and workshops about emotional and mental health. It would also be very beneficial to have educational psychologists, OJ counsellors and social workers available in schools and Yeshivos* to educate the children as well as the head-teachers and mashgichim* about emotional problems. This would enable the emotional and mental health problems among young people to be recognised. There are organisations like TMA which are well qualified and experienced to provide these services but they are under-funded and therefore are not in a position to even approach the head-teachers.

"I think they could do with much more – much more counselling. They can maybe start having counselling in groups which can be – very useful and I'm thinking more of the 17, 18 year old children, I mean they're not children, they're teenagers, for the simple reason of living with the condition of mentally ill parent, whether it's a mother or a father, can cause a lot of problems, and they've got many questions, and I think some of those questions have to be answered by somebody, otherwise in my opinion this on its own can cause mental problem".....Participant 5.

Also, another quote from the same participant:

Yeah, I think young people should be given explanation, they should understand the subject of mental illnesses, and they then would be able to understand the behaving problem of the parent, I think things will be quite different. It may not take the complete stigma, but if there will be groups, supporting groups, and the problems will be shared and they will realise there's more about, more teenagers like them which are putting up with a very similar situation..... Participant 5, Page 7.

A young person might be ostracised socially if they rebel against formalised religion. Some young people experience physical and emotional abuse at the hands of their elders.

"Those responsible for their education can be part of the problem, They might be the one who caused it in the first instance and then going to complain about them means that no one wants to believe the young person it is a vicious circle".....Participant 19

Further more:

"During schooling the young person may be abused.....Quite often the young person has a negative association with a more formalized religion. They naturally rebel -The religious identity may come from such experience. It is usually a reaction to earlier negative experience".....Participant 19.

This community prefers to utilise its own resources to meet its needs so that help offered is in ways that are consistent with its religious outlook and orientation. Many would only go to religious Jewish professionals, who they would trust to understand their way of life.

In this research a teenager wanted to leave her home and family; thus was put into sheltered accommodation that is part of the OJC structure. The girl started to wear jeans (it is totally forbidden for Orthodox Jews to "cross dress" for example for women to wear trousers and men to wear skirts/sarongs) and therefore she put her family to shame. She wanted to look "cool" and fit in with modern girls. She moved from a religious school to a less religious one and then did not want to go to school at all. She had really embarrassed and shamed her family openly so it might be too late to retrieve the relationship with her family.

Young people who are looking for "excitement" or "trouble" or who are being rebellious, are crying out for help. There are teenage girls and boys in Stamford Hill using drugs like marijuana, cocaine and speed.

"Eating a bacon sandwich, it really is a spiritual suicide but also...young people are using drugs and alcohol.Participant 19.

A community centre for teenage boys and for girls is needed in Stamford Hill according to some participants, as they need somewhere to go to get them off the streets. More and more children are getting confused with who they are and what they want and the parents become desperate. Some parents are forcing religion down the throat of their children hoping that this will solve their issues, but they are not listening. Parents

have high expectations of standards of behaviour and academic achievement from a child more than the child is willing to handle which increases emotional troubles and mental ill health among young people especially adolescent boys.

“High expectations: Mental health is so wide spread problem among young people because of too high expectations. Parents expect more from a child than the child is willing to handle”.
Participant 21.

Although the strictly OJC shows many of the features normally associated with childhood psychological disturbance, especially poverty, poor diet and large family size, in our interviews the data found that emotional problems among young people in the community were simultaneously similar to yet different from the rest of the population.

The way in which these problems manifest are less violent than perhaps in the wider community. There is no ‘gun or knife culture’. In comparison to other communities young people are supported in the OJ community, yet emotional problems in the OJ community are prevalent and widespread, appearances can be deceiving as there is so much denial. Most young people are emotionally stable only about 3% (Loewenthal, 2004) are not and most problems can be sorted out through talking therapies. Young people are not understood, Hackney is a hard neighbourhood in which to live.

If sexual abuse occurs in the OJC, the shame is so high that the statutory services are prevented from investigating as the community closes ranks. Young people have too many temptations from the wider secular society. There is also a lot of peer pressure within the community. Hence young people don’t get any support when they have emotional problems. They need to be encouraged to talk through their problems, with someone they trust who is older and wiser, not friends who can give bad advice. There needs to be Personal development courses for young people in the schools – in which they are taught to look within their own internal processes.

“Doesn’t know if young people concerns are taken seriously.. Young people have a lot of temptations from secular society... I think there is a lot of peer pressure in this community”.....Participant 25
and also :

“Young people need to be listened to more in the Orthodox Jewish community. There should not be denial, Allow their feelings”..... Participant 21.

Many boys’ schools in particular there are no school counsellors who may help identify and work with them and their emotional issues. The educators need to be willing to help more by listening to the young people. A good teacher will notice when a child needs support, but the young teachers who don’t have life experience or knowledge can destroy children through what they say. It’s important not to be rigid in the way children are treated. Young people need to be consulted when they experience physical / emotional problems. Children are raised in a patriarchal way to be obedient to their families and do as they are told and are often not encourage or even allowed to articulate how they feel. Some young people feel lost if they do not belong to a certain organization or do not do something like their parents. The commandment of ‘Honour thy father and thy mother’ is followed and in most families, parents and grand parents do sit in places of honour. Some parents have difficulty in emotionally supporting their children because they are generally in denial that there is a problem where their own child is concerned, and may send them abroad to family or institutions. The circular problem is that support is given from the same people who precipitated the problem in the first place.

Young people must have more help as not everyone’s life is happily focused on learning, to avoid poverty, marriage breakdown and a lack of direction in life. Young people need facilities, training opportunities, jobs and physical exercise to help them work out their mind, body and soul. Children of parents with mental health problems would need a specific therapy group to provide education and a safe place to talk.

All of the above section on youth, shows quite clearly that there is little or no engagement by the youth in decisions about their own lives. Changing this will be a mammoth task as it has been “the norm” since time immemorial compared to in the “wider” world where youth parliaments and forums are encouraged and supported. For the next generation, if prospects are going to change in terms of better outcomes through engagement, support has to be given now for the seed to germinate, develop and grow (DRE priorities see page 49)

5.3 SERVICE PROVIDERS

QUESTIONNAIRE B- SERVICE PROVIDERS

(Numbers at chart represent participant's answers, Total sample is eight)

Figure 1:

Q1. DO YOU THINK THE MENTAL HEALTH SERVICES YOU PROVIDE FOR THE ORTHODOX JEWISH COMMUNITY ADEQUATELY MEET THEIR NEEDS?

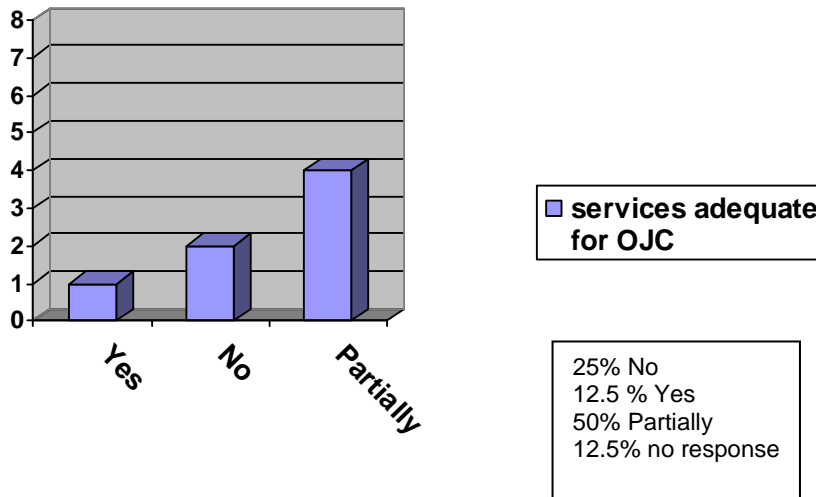


Figure 2:

Q2. HOW WOULD YOU DESCRIBE THE QUALITY OF THE MENTAL HEALTH SERVICES YOU ARE PROVIDING FOR THE OJ COMMUNITY?

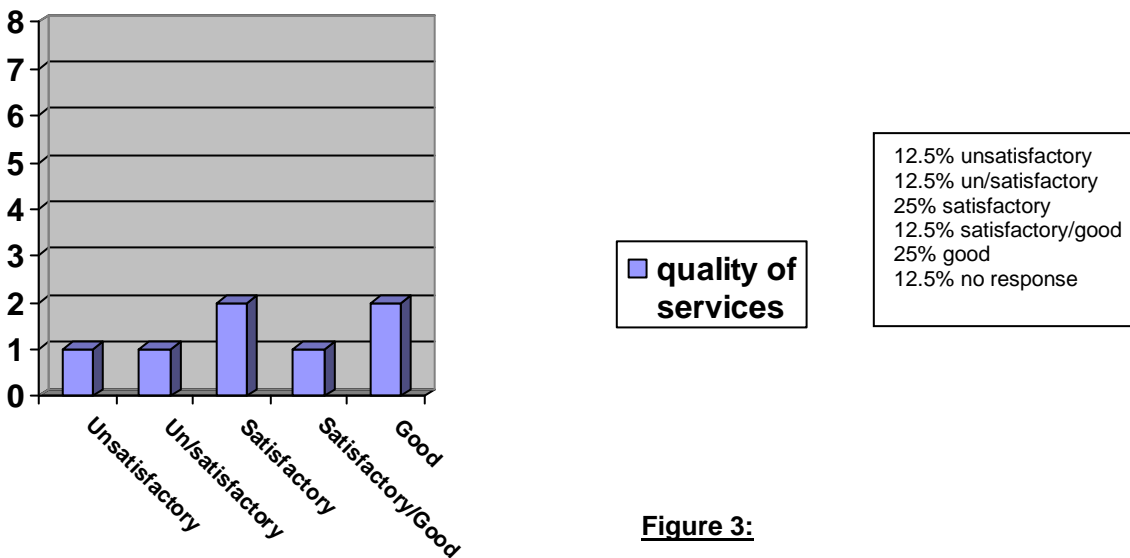


Figure 3:

Q3. DO YOU THINK THE SERVICE YOU PROVIDE IS CULTURALLY SENSITIVE TO THE ORTHODOX JEWISH COMMUNITY?

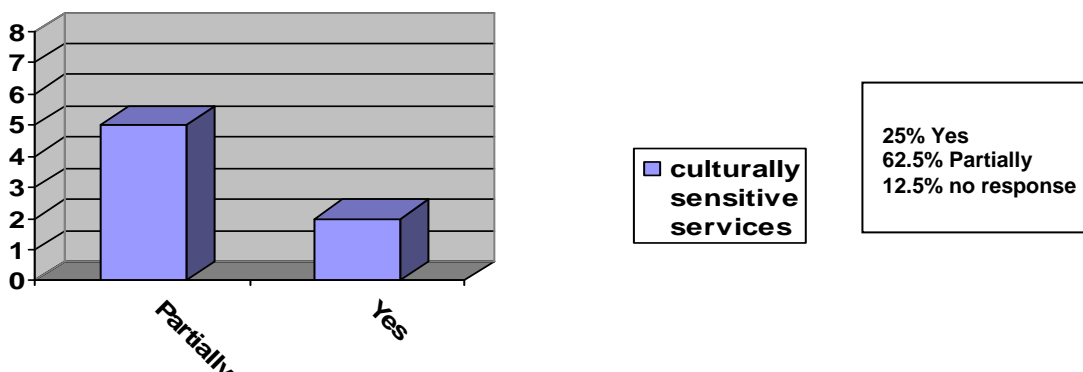


Figure 4:

Q4. HOW MUCH DO YOU KNOW ABOUT THE BELIEF SYSTEMS OF THE ORTHODOX JEWISH COMMUNITY?

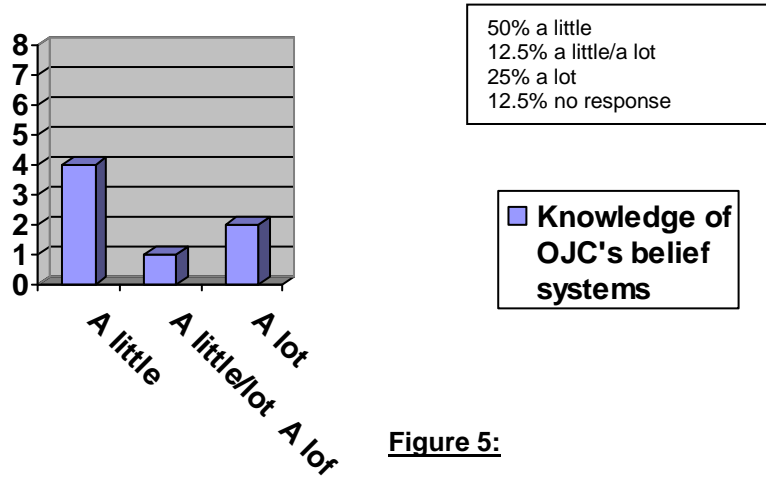


Figure 5:

Q5. IF YOU NEED INFORMATION ABOUT THE ORTHODOX JEWISH COMMUNITY, DO YOU HAVE ACCESS TO INFORMATION?

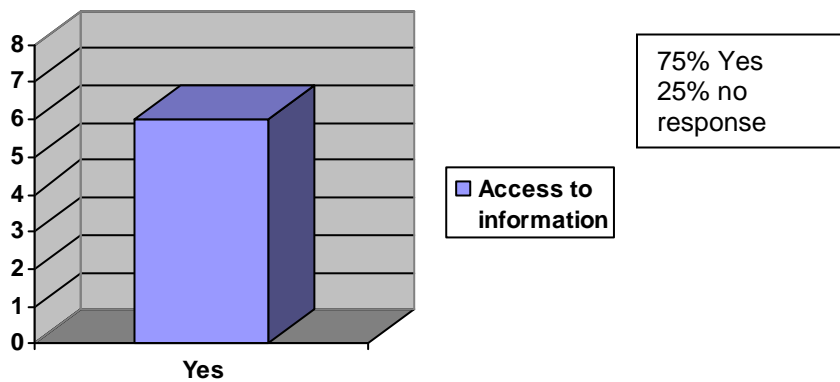


Figure 5a:

Q5A. WHERE DO YOU ACCESS YOUR INFORMATION ABOUT THE ORTHODOX JEWISH COMMUNITY?

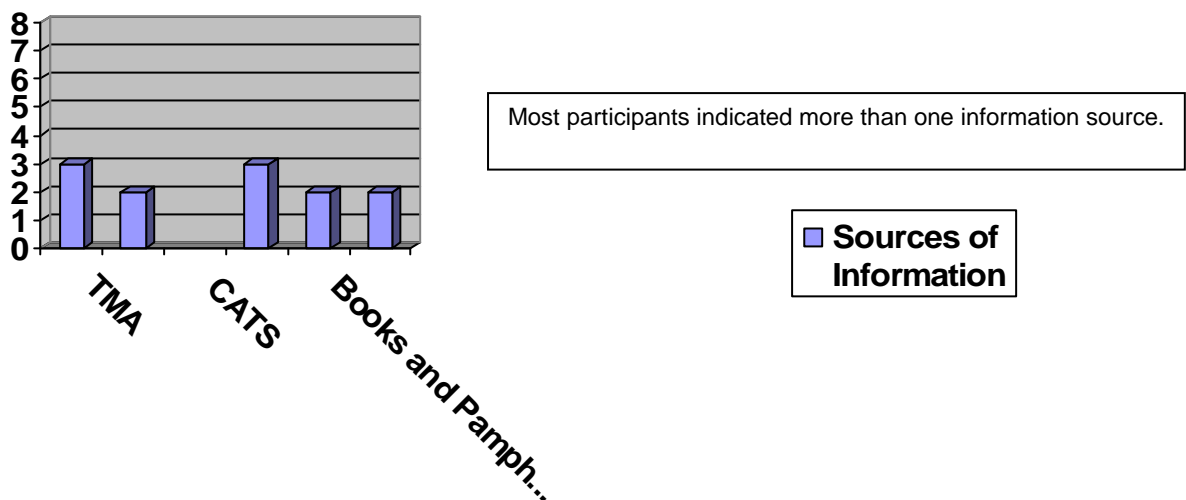


Figure 5b.

Q 5B. IF YOU DON'T HAVE ANY KNOWLEDGE ABOUT THE ORTHODOX JEWISH COMMUNITY, WHY DO YOU THINK THIS IS?

Answers included the following:

** "If people were more pro-active. That is the reason why I do not know. Food and religious days are obvious, but information- straight forward information sheets... would be useful"..... Participant 12*

** "I have no knowledge because of historically lack of contact, prior to working in the borough".. Participant 5.*

** "I do not know much because it's my 1st borough with an OJC... my previous case load has included ordinary borough".*

Figure 5c:

Q. 5C. WHEN PLANNING APPOINTMENTS OR MEETINGS FOR THE ORTHODOX JEWISH COMMUNITY, ARE YOU AWARE THAT ORTHODOX JEWISH PEOPLE ARE UNABLE TO ATTEND DURING THE SABBATH OR HIGH HOLY DAYS OR FESTIVALS?

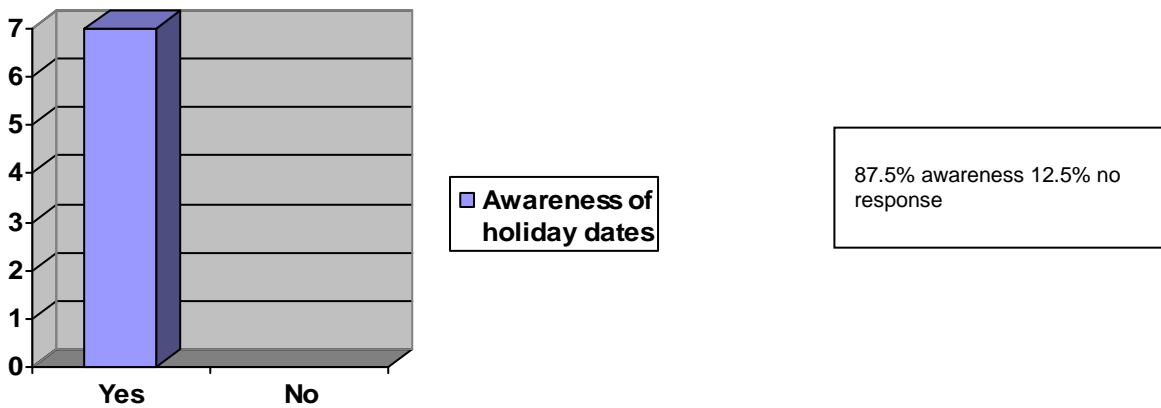


Figure 5d:

Q 5D. DO YOU TAKE INTO CONSIDERATION THE DATES AND TIMES OF SABBATH AND THE HIGH HOLY DAYS WHEN ARRANGING AN APPOINTMENT OR MEETING WITH A MEMBER OF THE ORTHODOX JEWISH COMMUNITY?

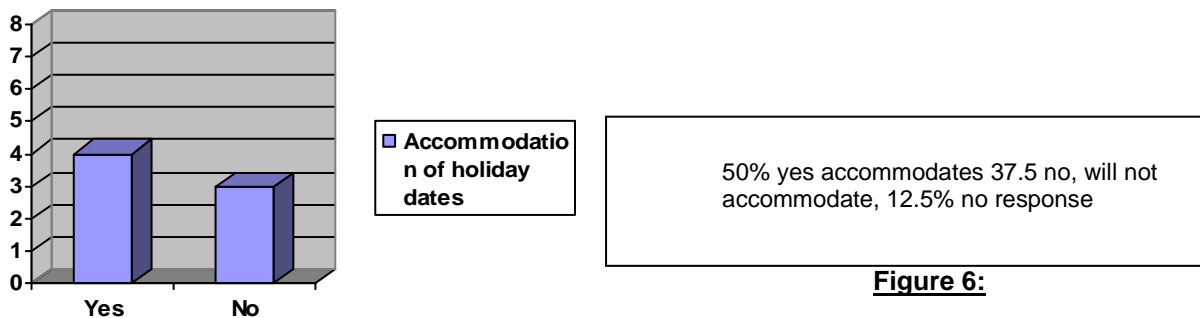


Figure 6:

Q 6. DO YOU HAVE A RELATIONSHIP WITH ANY ORTHODOX JEWISH ORGANISATION FOR CONSULTATIVE PURPOSES WITH REGARD TO THE MENTAL HEALTH SERVICES?

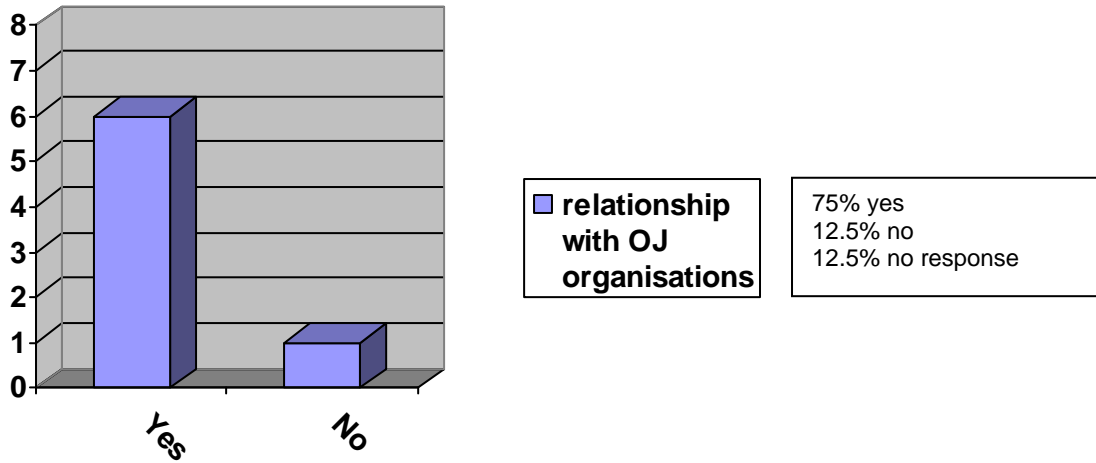


Figure 7:

Q 7. DOES YOUR ETHNIC MONITORING SPECIFICALLY REFER TO THE OJC?

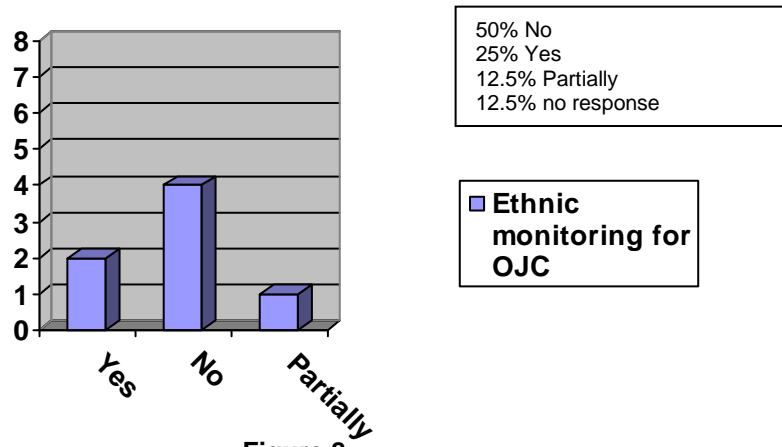


Figure 8:

Q 8. DO YOU COLLECT REGULAR FIGURES IN TERMS OF MINORITY COMMUNITIES SERVICE TAKE UP?

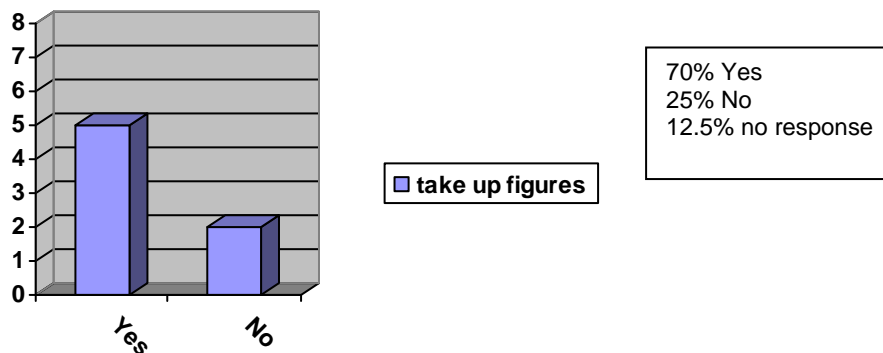


Figure 9:

Q 9. DO YOU KEEP STATISTICS ABOUT THE UPTAKE OF MENTAL HEALTH SERVICES BY THE ORTHODOX JEWISH COMMUNITY?

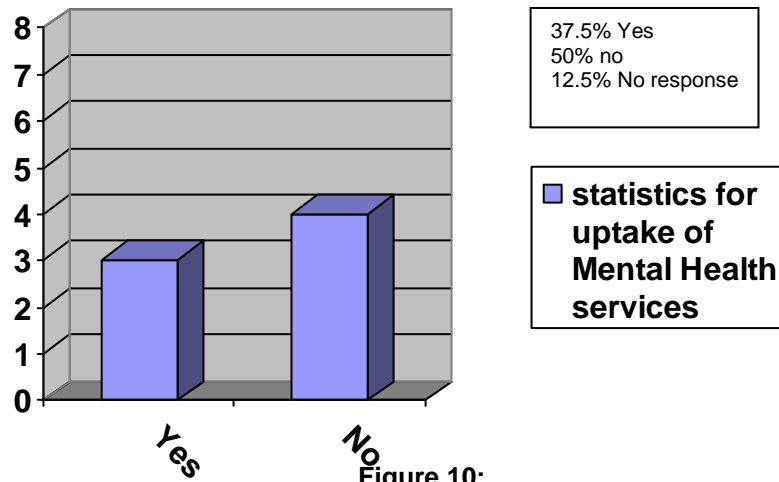


Figure 10:

Q 10. WHAT DO YOU THINK IS THE PREVAILING ATTITUDE TO MENTAL HEALTH IN THE ORTHODOX JEWISH COMMUNITY?

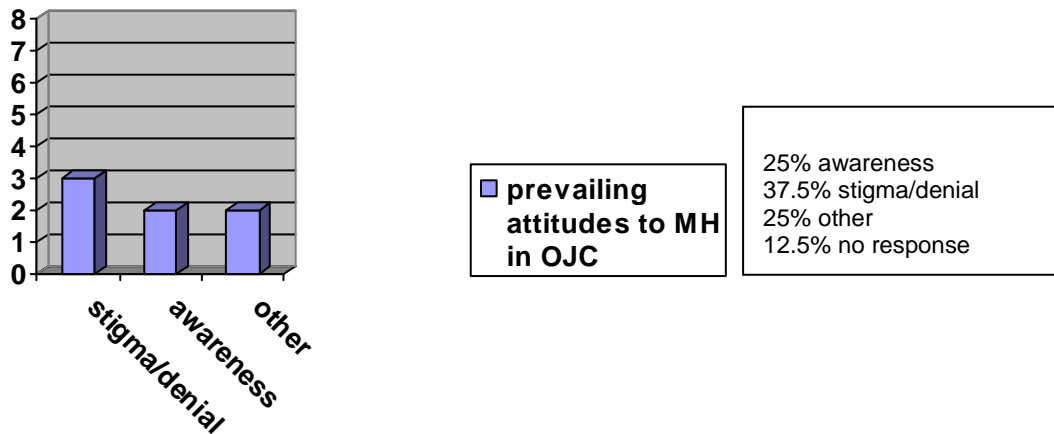


Figure 11:

Q 11. DO YOU FEEL THE OJC ADEQUATELY UNDERSTANDS THE NEEDS OF THOSE EXPERIENCING MENTAL HEALTH PROBLEMS WITHIN THEIR COMMUNITY?

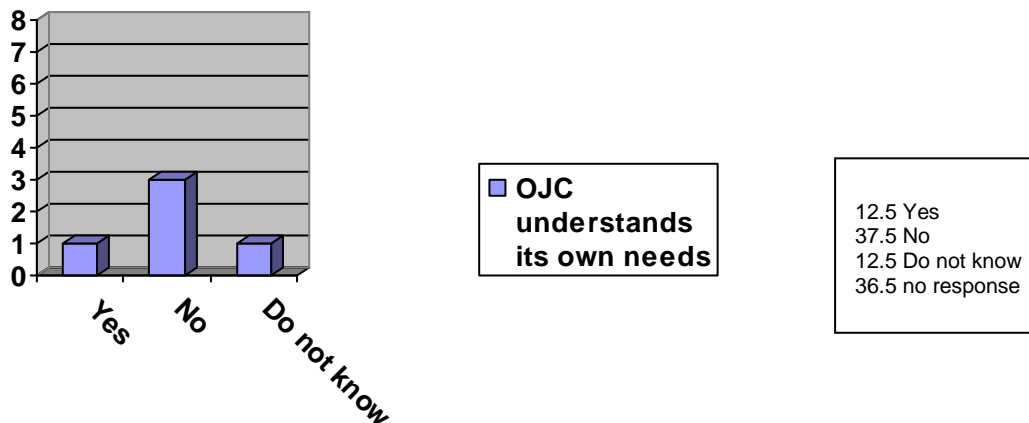


Figure 12:

Q 12. WHAT DO YOU THINK WOULD IMPROVE THE SERVICE UPTAKE OF YOUR DEPARTMENT?

Participant 1.	<ul style="list-style-type: none">• <i>Cultural sensitivity- more</i>• <i>Specialists</i>• <i>Specific workers from OJC</i>• <i>To be seen working with pamphlets- info</i>• <i>Awareness days</i>
Participant 2:	<ul style="list-style-type: none">• <i>More resources, wider reach</i>
Participant 3:	<ul style="list-style-type: none">• <i>Accessibility about service provision</i>• <i>Better knowledge</i>• <i>24 hrs and out of hours, the more accessible, the better.</i>
Participant 4:	<ul style="list-style-type: none">• <i>Greater awareness for OJC to know what's available/services (apart from shame) in wider world of OJC</i>• <i>Culturally specific needs/correctness is big</i>• <i>patients feeling they are receiving more culturally aware services</i>• <i>Psychiatric/intensive care</i>
Participant 6:	<ul style="list-style-type: none">• <i>Word of mouth- when families have had a good experience the word spreads.</i>
Participant 12:	<ul style="list-style-type: none">• <i>Maintaining the links that there are. Talks to women/men.</i>• <i>Information from us to them, and from them to us.</i>• <i>Trying to train up some psychiatrists. Training, conscious</i>

5.3 STATUTORY SERVICES: THEMES (from semi-structured questions):

Clash of culture , Orthodox Jewish services versus non-Jewish services, Stigma and denial

In analysing the interaction between statutory service provision and its OJ community (service) uptake it is apparent that underlying attitudes towards mental health and cultural needs influence this relationship. Loewenthal (2000) described 'reluctance to...seek help' because of stigmatisation and P9 explained that it is 'hard to interact with the Black and Minority Ethnic communities (BME) ...they do not understand us...' The accommodation of these attitudes determines whether improvements are made to services- and the limitations to service provision and its uptake can be attributed to the responsibility being seen to be that of the BME's rather than a two way process. 'It's an ongoing challenge' P9. More understanding of the OJC's unique system enables services to facilitate the community 'to get the best out of this system.' P9.

5.3.1 Clash of culture

An inhibitor in the community's uptake of statutory provision can be attributed to the culture clash between the two which is described by P9 as a 'reality.' The participant continues to describe how the misunderstanding about the OJC's culture is inevitable, not deliberate, with it being 'difficult for Hackney to understand the Chagim*' This was enumerated with the example of the Holyday of Passover which could be misconstrued to the outside world as an OCD- with its 'washing the entire apartment', P6 and concluded that it is therefore essential to know 'what is abnormal and normal' in order to overcome the barriers. An awareness of the different features that form the OJ lifestyle could be achieved by greater dissemination of information e.g. fact sheets/pamphlets. P1. Similar cultural awareness promotion was suggested, with suggestions for training and awareness days. P1.

However the extent of the effectiveness of cultural awareness days has been limited, and while services can be 'well meaning', P9, there can be disparity between its awareness and implementation. P7 described the spread of literature written on understanding of religious needs, and the fact that it can be 'counterproductive.' P1 described how though 'we try, generally we do not' provide adequately for the OJC. In this respect, it is up to the community also to be 'proactive' and get the best out of the system'. P9. Most participants did collect figures monitoring community service take up, less kept statistics, P12 explaining 'I suspect not, it was so little' and P1 expressing interest to do so.

This phenomenon features distinctly with regard to the Jewish Holydays, which are generally not understood with the regard needed to adequately accommodate OJ patients. - 'they still make meetings on Friday afternoon'. P9. The majority of the participants answered positively with regard to awareness of Jewish Holidays, yet only 2/3 had implemented change or practised accommodating them. P12 described accommodation in principle, but was 'not closely aware of what those days are' and P1 explained accommodating as 'Possibly, if meeting a Rabbi.' Although some organisations did have specific Jewish calendars, sent by other organisations, others used a multi-faith calendar, P5, and accommodated 'all religious events *when we can*'. This categorisation of the OJ community with other ethnic minorities was apparent in P12, describing that the Orthodox Jewish patients 'were treated the same', and 'did not demand anything extra'.

Another lack of differentiation found was between Jewish and Orthodox Jewish with regard to ethnic monitoring, see P1, P3 and P12, where monitoring took place without distinction between Jewish and Orthodox Jewish.

Another inhibitor to the provision of better services is the community's self-contained mentality which places its trust internally;

'The community want to access help from the kehilla*Participant 9.

Indeed one organisation which offers support services for users with acute mental health issues is seen as successful in that it does not need to prove itself as Charedi (ultra orthodox) based, and it is noteworthy that it is approved of by the UOHC – The Union of Orthodox Hebrew Congregations - the orthodox Rabbinic community body. In contrast, there is resistance to external influences with some 'small anti psychology groups active in using 'terror related methods' P7 and the community have developed their own charity organisations to fill the holes where the statutory 'does not meet needs'. P7. This self reliance is reflected in education too, schools are not funded properly, and only recently one senior school acquired state recognition and therefore funding from the government, realising their education 'is worth funding'. P6 revealed that the case load of those accessing services is 1/3 Jewish- about right for the area and emphasised also that when families do have good experience with statutory services, the word spreads.

5.3.2 Orthodox Jewish services versus non-Jewish services

P9 therefore calls upon the community 'get the best out of the system', by taking initiative and seeking 'simple solutions' to problems. The example of an anti Semitic comment on a wall in hospital that was pictured, rather than painted over was cited. This need to develop this 'assertive mental health' approach is supported by P12 who indicates that statutory services could be more knowledgeable about the OJC if 'people were more proactive.' This includes collaboration with the professional world, and P9 emphasised about Chizuk giving 'advocacy to psychiatry team,' and the fact that it was set up (1995) by the now national director of TMA whilst working for LB Hackney Social Services. The importance of dual communication to break the barriers was emphasised by P12 with the need for 'information from us to them and them to us'. The importance of maintaining the links that exist also surfaced.

There is evidence of links between the community and statutory services, with P3 acknowledging the different function each has to play- 'TMA for psychological' and etc. P6 had received a calendar with Sabbath times from another organisation and five of the participants had working relations with 3 or more Orthodox Jewish organisations.

The role of OJ professionals as a source of information for statutory services also featured positively; some organisations were informed through these contacts, P3, P5, and P1 expressed the need for more OJ specialists to help promote cultural sensitivity. P1. The role of the Jewish organisations was recognised in promoting health, 'TMA is more involved and has made drastic changes..' P3. P1 described a situation where a doctor had worked with the Rabbi to help cure a patient, and that this collaboration between experts was a 'product of good practice'.

5.3.3. Stigma and denial

The existence of stigma and denial around mental health issues in the OJC is featured in its response to services- both communal and statutory. Mental Health provision is still relegated to the extreme sector- P9 described how 80% of one organisation's service users are on the 'acute' side of mental health and the people accepted are 'dysfunctional' and have their 'life in turmoil'.

The manner in which community organisations cater for the community's mental health issues is reflective of their underlying attitudes. P9 explained that advertising would not bring in people; supporting the knowledge of the existence of the 'sweeping under the carpet approach' P7.

Three of the statutory services considered the prevailing attitude in the community to be one of stigma and denial, with P12 explaining the attitude as 'not really understanding'. The awareness that organisations like TMA were helping to change the trends and create 'drastic changes' with their health promotion, proves the existence of stigma that need yet be overcome. P3.

The organisation Yad Vo'Ezer (facilitating services for those with learning difficulties) was described as having 'broken the mould' P9. P7 described the extent of stigmatisation and hiding is such 'that people want to say that there is no stigmatisation...' This is an extra level of denial. The emphasis on the success of Jewish therapy through support groups in that 'users and volunteers as an equal' proves what an accomplishment this is within the community. Some of the users did feel 'accepted in the Kehillah*', yet stigma still affected them 'on a family level.' P9. Lowenthal (2000) elaborated how evidence for psychological disorders is limited in the community because of the 'reluctance to admit to problems and to seek help... Stigmatisation is the powerful factor driving the widespread view that s/he will grow out of it'.

This stigma apparent in mental health is correlated powerfully with regard to shidduchim (marriage partners)- as in the community 'it is all about who you are going to marry.' P9, and having mental illness will 'make you feel devalued'. This motivates much of the 'hiding,' though Dayanim* (Rabbinical Judges) would discourage de-legitimising the issues for this reason.

There is evidence that Mental Health is considered to be a different category of illness altogether, with a prediction that people 'will always worry' and that there is 'a certain hysteria about it' P9.

*

6. DISCUSSION

NOTE: The discussion section in a qualitative research such as ours is integrated into the findings and analysis section, thus no further elaboration can be found here, for our interpretation of the themes please read the previous section.

Evaluations: statements of personal evaluations from members of the Research Team

Below are brief personal statements by members of the research team, their experiences of being in the group, and what they learned. These thoughts are not necessarily those of Talking Matters or UCLAN but merely each one's view of the outcomes whilst in the project, and to inform others who may be considering community research projects in the future.

Miss Shulamis Abraham

"It has been inspiring, experiencing the diverse backgrounds and abilities of the research group, pulled together for the project. Seeing how the research procedure itself can catalyse change, just by giving people a legitimate voice, and that the needs of the community exist in an underworld of turmoil that respond to this opportunity of self expression.

I have grown from being transported into a person's world for an hour and then having to leave them with their struggles and strengths. I have seen the power or re-occurring patterns and the underlying difficulties."

Mrs Suzanne Cohen

"I was happy to be able to contribute to increasing the knowledge about mental health issues the OJC, using my skills. I learned more about Judaism, on a personal level and it was good to discover things about my own background that I didn't know previously"

Mrs Leah Feldman

"Being that I am working in the community, I was not surprised at the findings of this research. Yet it was a wonderful experience, to see the evidence on paper. I feel it has been a privilege and very exciting at the same time to have been part of this team and hope that this work will benefit the community in the not too distant future."

Rev Nota Kreiman

"This was the first time I was engaged in a community research programme, and I gained some valuable interview skills, an insight into how to construct questionnaires which are culturally sensitive and which illicit the information needed. I do hope our findings will bear fruits in active service provision"

Dr Nadia Loewke-Kinn

"I have gained the confirmation that there is a great need for psychological intervention in the OJC and there is obvious disillusion and lack of confidence in the people that traditionally have provided the support. I've also been impressed with the standard of the work produced by the research group."

Ms José Martin

"A very valuable aspect of this work has been interviewing statutory service providers and the disparity in their views about their own effectiveness and cultural sensitivity in service provision. In one case the provider perceived their service to be 'A1' and was in fact, according to the service users, the least used, effective or culturally sensitive.

Generally the most inspiring point of this research has been the willingness of the clients to open up about issues which historically have been and to a certain extent, still are - stigmatising. It was with some trepidation that we momentarily entered their lives and with great humility that we recorded their experiences and feelings. I have been reminded of the fragility of the human mind and saddened by some of the community responses that various service users and their families have had to endure. *No one* should have to suffer such treatment as a result of judgementalism and ignorance.

Mrs Shani du Sautoy

“It was a fascinating experience to work in close proximity with members of the orthodox Jewish community. Although I am a Jewess, the ‘ins’ and ‘outs’ of the community and how it lives were unfamiliar to me. The manner in which the participants expressed themselves highlighted to me some of the unique ways of thinking about issues of mental health, and the way these perceptions influenced their solutions.

I learned a lot about administration which I didn’t know before and the day to day running of a project like this especially given the differences in cultural norms like time keeping and family priorities over work”

Mrs Malka Taub

“The project has given me an insight as to what is going on in my own community. I had an experience of the opening of a crack where people are starting to be willing to voice certain issues and problems. I found it enlightening to experience something I had wanted to see with my own eyes – the realness.”

*

7. CONCLUSION:

It is interplay of internal and external features that affect the provision and uptake of statutory services. Stigma and denial within the OJC towards mental health, inhibit service uptake as well as its insular mentality and self contained organisations. The OJ services that are in operation within the community are “helping break the mould” and although some statutory services are well informed, the majority do not in provide ‘good enough’ services to cater specifically for the OJC’s needs. It is in Participant 9’s words, “an ongoing challenge”, and the need to implement change both proactively and realistically is emphasised.

EDUCATING THE COMMUNITY

As a direct result of the lack of knowledge and therefore misunderstandings towards mental health issues a lot of work needs to be done in educating the community. This will ensure that less stigma is attached to mental illness, service take up would be greater and service users would be more at ease with the services. It can not occur over night and it may take some years, however, even a long journey starts with a small step. The participants of this study indicated that the leaders of the community are not always fully informed of the possibilities of treatment that are on offer. Some leaders do refer individuals to professional orthodox counsellors but some would restrict their recommendations to prayer and religious obligations. Schools are one of the most important parts of the community where a good start could be made in order to bring about real change, headmasters, teachers and students could be made aware of mental health issues, what to look for and where to find support and help.

EDUCATING THE OUTSIDE WORLD

If trust is to be given to non-Jewish service providers by the community, further and deeper understanding is needed. Cultural awareness of issues such as dress code, moral behaviours, norms and customs, as well as practical issues is urgently needed. Although the local PCT is aiming to improve and indeed does have change on the agenda, some of its practices leave a “little to be desired”. Further liaising with all OJ organisations within the community that already have an invested stake in the mental health arena are the way forward to close the gaps of knowledge and accessing adequate service provision.

*

8. RECOMMENDATIONS

In assessing all that has been researched and reported through this community engagement programme, there are themes and issues which re-occurred in nearly every service users' interviews. As a disparate group of Jews living in the area, mostly Ultra Orthodox, with but one or two non religious Jews we had to learn to work cohesively and in the same direction at all times. What transpired in that process was the prising open of centuries of hidden issues, and like Pandora's box, once opened there has been no going back. Most of the team however, were really not surprised at what came out. It has been as if we all knew what was in the box but the Community Engagement Programme has been the key to unlocking it.

Our recommendations from the findings are divided into the themes as found in the report:

1. Diagnoses
2. Torah, culture, Rabbis and Rebbitzens
3. Understanding of Mental Health in the OJC
4. Service take up
5. Women
6. Youth
7. Other emerging issues
8. Participants' recommendations

As establishing new services and support systems as well as developing existing ones, all require funding to be real, the following recommendations are all based on that premise;

8.1. Diagnoses

- a. Produce printed information in mother tongues, from within the community on symptoms of mental illness, early intervention and accessing professional help both in and out of the community in the next year
- b. Establish and provide culturally sensitive educational training seminars on issues of diagnoses and accessing services for differing social groups, for example: schools, youth groups, men and women as soon as possible

8.2. Torah, culture, Rabbis and Rebbitsens

- a. Establish and provide culturally sensitive educational training seminars on issues of mental health and stigma for Rabbis, Rebbitsens and community leaders within the next financial year
- b. Establish a discussion group with the Rabbis to un-pick the confusion between cultural beliefs versus religious beliefs regarding mental illness within the next 2 years
- c. Increase the number of culturally sensitive counselling sessions/hours available to the community from professionals within the OJC as soon as possible
- d. Provide more written information in mother tongues about the existing OJ services for mental health and wellbeing for Rabbis, Rebbitsens and community leaders, now.

8.3. Understanding of Mental Health in the OJC

- a. Produce printed information in mother tongues, from within the community on "The Mind", its psychological and physiological make up, stress triggers, food & mood and support mechanisms, this year
- b. Establish and provide culturally sensitive support groups on issues of fear, stigma and the dangers of denial, as soon as possible
- c. Develop existing counselling training courses for community members that are both vocational and at national qualifying level, within the next 3 years
- d. Develop further training courses in psychological and talking therapies for the existing counsellors and therapists in specialist issues like youth counselling, couple counselling and

CBT to deal with the issues more effectively and for a more balanced range of therapies, to commence September 2007,

- e. Provide clinical supervision and support for existing counsellors and therapists, for stronger services within the next 18 months

8.4. Service take-up

- a. Employ at least 2 OJ counsellors and therapists in the statutory sector within this financial year (or full time equivalent, one male and one female)
- b. Improve and increase the appropriateness of statutory service provision through the provision of Cultural Awareness Training Seminars (CATS) by OJ service providers at the start of this financial year
- c. Produce printed information in mother tongues, from within the community on statutory service provision, what to expect, which Rabbis support using the service and the dire consequences of not attending to the psychological needs of their family members, this year.

8.5. Women

- a. Establish a divorced and single women's support group, as soon as possible
- b. Re-establish the Post Natal Depression group (originally started through Sure Start) or an OJ women's counselling service, within the next year
- c. Link into the existing OJ women's group on domestic violence, and help establish a forum for discussion with the Rabbis and the Rebbitzens on women's issues, stigma and mental health, as soon as possible

8.6. Youth

- a. Produce printed information in mother tongues, from within the community for young people on stress prevention, communication and mental wellbeing, now.
- b. Establish and provide culturally sensitive youth educational training seminars or discussion groups on issues of mental health for schools and youth groups, in the next 18 months
- c. Establish and provide non judgemental OJ youth counselling and/or mentoring services, through the employment of 2 youth counsellors (or full time equivalent, one male and one female) this year
- d. Re-establish short courses for parents (Family Seminars) on issues of family dynamics, parental education and youth culture in the next financial year
- e. Establish and provide short courses and printed information in mother tongues for Rabbis and teachers on modern day youth culture, this financial year
- e. Establish and provide an OJ support group for children whose parents have mental health problems, in this financial year
- f. Establish and provide an OJ support group for teen-agers whose parents have mental health problems, in this financial year

8.7. Other emerging issues

- a. Establish qualitative research project on levels of substance abuse in the community in next 3 years
- b. Establish short to medium term non-stigmatising parenting training courses for couples in the next 2 years

9. ACTION PLAN BASED ON THE RECOMMENDATIONS

Theme	Item	Action	Target Group	Timescale	Responsibility
Diagnoses	<ul style="list-style-type: none"> Symptoms of mental illness, early intervention Accessing professional help both in & out of the community 	<ul style="list-style-type: none"> Produce printed information in mother tongues, from within the community 	<ul style="list-style-type: none"> OJC 	2007 - 8	TMA
	<ul style="list-style-type: none"> Issues of stress prevention, early diagnoses, mental wellbeing Accessing services 	<ul style="list-style-type: none"> Establish & provide culturally sensitive educational training seminars 	<ul style="list-style-type: none"> Schools Youth groups Men and women 	2007 - 8	TMA
Torah, culture, Rabbis and Rebbitzens	<ul style="list-style-type: none"> Mental health and stigma 	<ul style="list-style-type: none"> Establish & provide culturally sensitive educational training seminars / discussions 	<ul style="list-style-type: none"> Rabbis Rebbitzens Community leaders 	2007 - 8	TMA
	<ul style="list-style-type: none"> Un-pick the confusion between cultural beliefs versus religious beliefs regarding mental illness 	<ul style="list-style-type: none"> Establish a discussion group 	<ul style="list-style-type: none"> Rabbis Rebbitzens Community leaders 	2007 - 9	TMA
	<ul style="list-style-type: none"> Extend the number of culturally sensitive counselling sessions/hours available 	<ul style="list-style-type: none"> Increase sessions 520 per annum to 650 Increase sessions 650 per annum to 750 	<ul style="list-style-type: none"> Service users in OJC Referrals from Rabbis & GPs 	2007 – 8 2008 – 9	PCT
	<ul style="list-style-type: none"> Existing OJ services for mental health and wellbeing 	<ul style="list-style-type: none"> Provide more written information in mother tongues 	<ul style="list-style-type: none"> Rabbis Rebbitzens Community leaders 	2007	TMA
Understanding of Mental Health in the OJC	<ul style="list-style-type: none"> “The Mind”, the psyche, physiological make up, stress triggers, food, mood and 	<ul style="list-style-type: none"> Produce printed information in mother tongues, from within the community 	<ul style="list-style-type: none"> OJC 	2007 - 8	TMA

	support mechanisms				
	<ul style="list-style-type: none"> • Fear, stigma and the dangers of denial 	<ul style="list-style-type: none"> • Establish and provide culturally sensitive support groups 	<ul style="list-style-type: none"> • OJC 	2007 - 8	TMA
	<ul style="list-style-type: none"> • Training courses 	<ul style="list-style-type: none"> • Develop existing counselling training courses that are both vocational and at national qualifying level 	<ul style="list-style-type: none"> • OJC 	2007 - 10	TMA with PCT/ELMHT
	<ul style="list-style-type: none"> • Psychological and talking therapies in specialist issues to deal with the issues more effectively and for a more balanced range of therapies 	<ul style="list-style-type: none"> • Develop further qualifying training courses in youth counselling, couple counselling and CBT 	<ul style="list-style-type: none"> • Existing OJ counsellors and therapists 	2007- 8	TMA with PCT/ELMHT
Service take up	<ul style="list-style-type: none"> • For increased service take up in the statutory sector 	<ul style="list-style-type: none"> • Employ at least 2 x OJ counsellors and therapists from Talking Matters (or full time equivalent, one male and one female) 	<ul style="list-style-type: none"> • Existing OJ counsellors and therapists 	2008-9	PCT or ECMHT
	<ul style="list-style-type: none"> • Improve and increase the appropriateness of statutory service provision 	<ul style="list-style-type: none"> • Through the ongoing provision of Cultural Awareness Training Seminars (CATS) by Orthodox Jewish service providers (Talking Matters) 	<ul style="list-style-type: none"> • All service providers 	2007- 8	PCT and ELMHT
	<ul style="list-style-type: none"> • Statutory MH service provision 	<ul style="list-style-type: none"> • Produce printed information in mother tongues, from within the community on what to expect when using the service • The dire consequences of not attending to the psychological needs of their family members in 	<ul style="list-style-type: none"> • Rabbis 	2007 – 8	TMA

		the first instance			
Women	<ul style="list-style-type: none"> Social inclusion 	<ul style="list-style-type: none"> Establish support group 	<ul style="list-style-type: none"> Divorced & single women 	2007 - 8	TMA
	<ul style="list-style-type: none"> PND 	<ul style="list-style-type: none"> Re-establish the Post Natal Depression group (originally started through Sure Start) or an OJ women's counselling service 	<ul style="list-style-type: none"> Women with PND or OJ women 	2007 - 8	TMA with ELCMHT or PCT
	<ul style="list-style-type: none"> Domestic issues stigma and mental health 	<ul style="list-style-type: none"> Link into the existing OJ women's group on domestic violence, help establish a forum for discussion with on women's issues 	<ul style="list-style-type: none"> Rabbis Rebbitzens 	2007 - 8	TMA
Youth	<ul style="list-style-type: none"> Stress prevention, communication & mental wellbeing 	<ul style="list-style-type: none"> Produce printed information in mother tongues, from within the community for 	<ul style="list-style-type: none"> Youth 	2007 - 8	TMA
	<ul style="list-style-type: none"> Mental health and wellbeing 	<ul style="list-style-type: none"> Establish and provide culturally sensitive youth educational training seminars or discussion groups 	<ul style="list-style-type: none"> Colleges schools youth groups 	2007 - 2110	TMA
	<ul style="list-style-type: none"> Counselling and/or mentoring services, 	<ul style="list-style-type: none"> Employ 2 OJ youth counsellors (or full time equivalent, one male and one female) 	<ul style="list-style-type: none"> OJ youth 	2007 - 8	TMA and PCT or ELCMHT
	<ul style="list-style-type: none"> Family dynamics, parental education 	<ul style="list-style-type: none"> Re-establish short courses for (Family Seminars) on issues of 	<ul style="list-style-type: none"> Parents 	2007 - 8	TMA
	<ul style="list-style-type: none"> Modern day youth culture 	<ul style="list-style-type: none"> Establish and provide short courses and printed information in mother tongues 	<ul style="list-style-type: none"> Rabbis Teachers 	2007 - 8	TMA

	<ul style="list-style-type: none"> Those whose parents have MH issues 	<ul style="list-style-type: none"> Establish & provide an OJ youth support group 	<ul style="list-style-type: none"> Children under 13 	2007 - 8	TMA
	<ul style="list-style-type: none"> Those whose parents have MH issues 	<ul style="list-style-type: none"> Establish & provide an OJ support group, 	<ul style="list-style-type: none"> Youth 14+ 	2007 - 8	TMA
Other emerging issues	<ul style="list-style-type: none"> Levels of substance abuse in the OJC 	<ul style="list-style-type: none"> Establish qualitative research project 	<ul style="list-style-type: none"> Users Providers 	2007 - 10	TMA
	<ul style="list-style-type: none"> Parenting training courses 	<ul style="list-style-type: none"> Establish short to medium term non-stigmatising support group 	<ul style="list-style-type: none"> Couples 	2007 - 9	TMA

DELIVERING RACE EQUALITY TO THE JEWISH ORTHODOX COMMUNITY

Government DRE guidelines:

1. Less fear of mental health care and service among BME communities and BME service users.
2. Increased satisfaction with services.
3. An increase in the proportion of BME service users who feel they have recovered from their illness.
4. A more balanced range of effective therapies such as peer support services, psychotherapeutic and counselling treatments, as well as pharmacological interventions that as are culturally appropriate and effective.
5. A more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and
6. A workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

The recommendations according to the participants in this study feed into the above guidelines.

- What we would like, is for UCLAN to give out a list at the start of the training programme covering all PCTs and MHTs (Mental health trust) around the country as to
 - Who and where are the Ethics Committees
 - Name of the chair and the contact details and
 - What are the criteria for requiring ethical approval

This would save much time (and money), energy and stress for all groups in the programmes, as they all have to do the same journey which must be equally frustrating for all concerned. Another reason this is so important, is that many of the people in this programme are mental health service users. The levels of stress caused as a result of trying to establish who and where the ethics committees are, and the time spent in trying to establish this could all be avoided and make the process a much happier one.

*

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11. LIST OF TABLES AND FIGURES

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- Figure 2 – main thematic findings of Questionnaire A – page 18
- Figure 3 – Charts of Questionnaire B – page 32.

12. GLOSSARY

Ashkenazim: A term that originally meant German Jews, due to the fact that country had one of the first sizeable Jewish communities in Europe.

Nowadays denotes European Jews.

Ba'al Shem Tov, Rabbi Yisrael: The Founder of the Chassidic Movement (lit. 'Master of the Good Name')

Ba'al Teshuva: A Jew who becomes (more) observant. (lit. 'Master of repentance')

Bar Mitzvah: A boy who, at the age of 13, reaches Jewish adulthood and becomes responsible to observe the commandments of the Torah. (lit. 'Son of the commandments')

Bal Tashchit: A principle prohibiting the causeless destruction of anything useful or valuable.

Bas Mitzvah: A girl who, at the age of 12, becomes responsible to observe the commandments of the Torah. (lit. 'Daughter of the commandments')

Beth Din: A Rabbinic Court (lit. 'House of Justice')

Bris Milah: Circumcision as a physical sign of the bond between the Jews and G-d, as laid down in Genesis. (lit. 'covenant of circumcision')

Chametz: Grain products that have undergone fermentation, e.g. bread, cake, biscuits, etc.

Chamin: Sephardi version of the Cholent

Chareidi: Those who tremble

Chavrusah: A method of study (in pairs) developed in the yeshivot (Aramaic for companion)

Chassid/Chossid: Pious one

Cholent: Meat and beans dish traditionally served on Shabbat. (lit. fr. Chaux lent)

Chuppah: The wedding canopy

Daf Ha'Yomi: Method of Torah study whereby a different page of the Talmud is studied daily.

Gadol Hador: The leading sage of the generation

Gefillte Fish: Fish roulade traditionally served on Shabbat (lit. 'filled fish')

Ghetto: Segregated area/walled part of a town – originally only for Jews.

Gemillut Chassadim (abbr. gemach): General term for good deeds. (lit. giving kindness)

Haggadah: A collection of teachings relating to the Israelites' slavery in Egypt and their miraculous departure (lit. 'telling').

Halachah: Guidelines for living as a Jew, often referred to as 'Jewish law' (lit. 'going').

Kabbalah: A term used for Jewish mysticism (lit. that which is received).

Kollel: Advanced Jewish academy of higher standard than a yeshiva for married men
Kashrut, adj. kosher: The right kind of food for Jews to eat/ correct for use (lit. 'fit'/right')

Kindertransport: Emigration of about 10,000 children from Germany to Great Britain in the early stages of World War II

Kristallnacht: Night of 9 November 1938, when most synagogues in Germany were destroyed, Jews beaten and arrested.

Latkes: Oily potato pancakes traditionally eaten on Chanuka.

Maimonides (Rambam): Rabbi Moshe Ben Maimon (1135 – 1204), Jewish philosopher and one of major halachic authorities.

Matzah: A mixture of flour and water baked quickly to form thin, unleavened bread eaten on Pesach.

Mechitzah: A separation/ division (between men and women) for religious purposes.

Mikvah: Pool of natural water for ritual immersion.

Mishna: The written version of the oral Torah (lit. repetition)

Mitzvah, pl. Mitzvos: The 613 commandments in the Torah (lit. commandment)

Niddah: The period of time when a woman starts menstruating until she finishes and has immersed herself in a mikvah.

Omer: The 49 day mourning period between Pesach and Shavuoth.

Orthodox: Strictly observant (Gr. 'orthos doxa' – straight thinking)

Pesach: Passover

Rabbi: Term of respect similar to the English 'sir' – community leader (lit. 'my teacher')

Rambam: See Maimonides

Rebbe: Leader of any Chassidic group, considered a spiritual leader and direct link to God

Seminary: Institution of advanced Jewish learning for girls; the equivalent of a yeshiva. Colloquially known as "Sem".

Sephardim: Originally the Jews of Spain and Portugal, now a term for oriental Jews in

general

Shabbat/s: The Sabbath, the 7th day of the Jewish week, the period from sunset on Friday until nightfall on Saturday.

Shadchan: Matchmaker

Shechitah: The Jewish method of the ritual slaughter of animals for food (lit. slaughter)

Shtieble: Place of worship (Chassidic style) (lit. 'small room')

Sheitel: Wig worn by observant (married) women.

Shidduch, pl. Shidduchim: the observant way of 'dating' for marriage.

Shiur, pl. Shiurim: Religious lecture/s (lit. measure)

Shtreimel: Black furry hat worn by Chassidic men on Shabbat and festivals

SS: Initials standing for Schutz Staffel, meaning protection squad

Synagogue/Shul: Place of worship and communal events (yidd. lit. 'house of assembly')

Talmud: Commentary on the Mishna.

Torah: The first 5 books Moses, the Jewish "Bible"/ the whole Jewish teaching (lit. instruction)

Tsnius, adj. Ts'nua: The rules of modest dress code. (lit. modesty)

Yeshiva: Talmudic academy. The oldest form of Jewish College. (lit. 'place of sitting')

Yichud: An inappropriate situation, where a man and a woman are together in a room on their own (lit. togetherness)

Yom Tov: Religious Festival

13. APPENDICES

APPENDIX 1 – DEMOGRAPHIC FIGURES FOR STAMFORD HILL, N16

Geography	<ul style="list-style-type: none"> • North/North East London • London Boroughs of Hackney/Haringey • Hackney is in Inner London • PSE indicators, last column <p>A = Total Weekly Household Income Estimate by Households in £ sterling (April 01 – March 02) B = Jobseeker’s Allowance, claimants; Total Person count C = Indices of Deprivation 2004; Combined Income Indicator, persons count D = Income Support Claimants, Total persons count</p> <ul style="list-style-type: none"> • 							
Demography Taken from Census 2001, where OJ was not an option re BMEs but was under religion, so many OJs are in “White”,	Ward	Pop.	OJs by Religion	BMEs	PSE indicators			
Cazenove	10,504	13% 1,365	White 6,033 Mixed 395 Asian 1,723 Black 2,116 Chinese 61 Other 176	A 550 0	B 305	C 339 5	D 116 0	
Lordship	11,288	17% 1,919	White 8,293 Mixed 271 Asian 661 Black 1,594 Chinese 76 Other 393	A 610	B 260	C 312 0	D 115 0	
New River	11,515	20% 2,303	White 7,481 Mixed 413 Asian 857 Black 2,310 Chinese 105 Other 349	A 490	B 360	C 391 0	D 149 5	
Springfield	10,854	24 % 2,604	White 6,805 Mixed 420 Asian 1,011 Black 2,305 Chinese 64 Other 249	A 470	B 305	C 373 0	D 143 0	
Totals	44,161	Av. 18.5 8,191*	White 28,612 Mixed 1,499 Asian 4,252 Black 8,325 Chinese 306 Other 1,167					
Population	<p>(* This figure (8,191) is not a true figure as mentioned above, plus many OJs are still fearful of putting “Jew” on any official papers as they remember how such figures were used by the Nazis)</p> <ul style="list-style-type: none"> • According to Holman & Holman in 2002 the OJ population is approximately 20,000 • This can be verified through the fact there are about 3,500 families in the OJC (synagogue membership) and the average family size is 6.9 (Loewenthal), which equals about 24,000. • The OJC of Stamford Hill is the largest Chassidic community in Europe, 3rd largest in the world after New York and Israel. • Within LB Hackney, the OJC are about 10% of the total population of 210,000 							

Local mix of population	From the figs above and using Holman and Holman, in the 4 local wards within the constituency of Hackney North and Stoke Newington, the population is made up as follows:		
	Racial group	Numbers	%
	White	8,612	19.50
	OJ	20,000	45.28
	Mixed race	1,499	3.39
	Asian	4,252	9.63
	Black	8,325	18.85
	Chinese	306	0.70
	Other	1,167	2.65
	Totals	44,161	100
Local mix of OJC	Descent by % from TMA service use		
	Hungary	15	USA/Canada 4
	UK	11	Czech Republic 4
	Poland	7	Romania 4
	India / Iraq	7	Baltic States 3
	Germany /Austria	6	USA/Canada 2
	Israel	6	Scandinavia 2
	North Africa	6	Far East 1
	France	6	South Africa 1
	Persia/Iran	5	Other 1
	Aden/ Yemen	5	Total 100
	Russia (USSR)	4	
	Languages spoken	<ul style="list-style-type: none"> Nearly everyone understands English but The Lingua Franca is Yiddish (Colloquial Hungarian) Some speak Hebrew There is a sizeable minority who are French and Arabic speakers Many of the men in full time Rabbinical colleges severely lack literacy and numeracy skills as it is generally not taught in their schools 	
Refugees/Asylum seekers	We are mainly a community of refugees, now in our 3 rd and 4 th generations		
Service user take up	1995 - 4 new service users with mental illness) 2000 - 26 " ") * 2005 - 24 " in only quarter 1!) Figs from; (EL&CMHT, Homerton University Hospital and C&H NHS PCT, * anxiety, schizophrenia, depression, eating disorders, pre-senile dementia and personality disorders)		
Gender take up of service	The only indicators available are those from <i>our</i> service users When the project was being researched the following figures were the % take up of service by gender; 94% female and 6% male By the time the project had completed this had changed to; 66% female and 34% male		

APPENDIX 2, Project TIME TABLE

MONTH	ISSUE	METHOD
JAN - APRIL 2006 1	Pre Planning for bid	<ul style="list-style-type: none"> • Researched what info was available • Bid • Web search found nothing available on MH in OJC needs analysis • Asked service users • Major stakeholders LBH NHS MHT • Steering group to be organised, made list of possibles in OJC • Got their tentative agreement • As marrying off one's offspring is an essential commandment for parents, most interviewees would not trust anyone who was "just" a community member, but would trust someone who is known to be confidential & professional as counsellors/therapists). So it was agreed by that the researchers could be counsellors from OJC (Olivia Nuamah REL London)
MAY 2006 2	Recruiting researchers	<ul style="list-style-type: none"> • With laymen there is no trust because of shidduchim (organised marriages) and everybody knows everybody else - There would also be a withholding of replies and information • Contacted by TMA who sent out a written description of the research • 15 signed up • 10 agreed out of whom 8 transpired and agreed to do the process
JUNE 2006 3	Meetings of the steering group Questions	<ul style="list-style-type: none"> • Initially met to discuss who would be best placed to be on the steering group, from both the OJC, voluntary and statutory sectors • What would be the necessary house rules? • What would the key issues be? • How could the "street knowledge" be evidenced? • Issues discussed included: <ul style="list-style-type: none"> • Recognising and owning emotions • Statutory services • Stigma about Mental Health • Perennial social issues of fear, stigma and denial • Other main issues were; <ul style="list-style-type: none"> • The effect of parents having to organise successful marriages • The cause and effect of denial • Problems about young people and their behaviours and • What methods to employ and • How to differentiate between respondents' cultural norms and the perceptions of the researchers
JULY 2006 4	Training and support – Attending workshops by UCLAN	<ul style="list-style-type: none"> • Planning on how to develop and extend knowledge • Understanding of the issues involved in conducting community based research Once every week • 4researchers attended

		<ul style="list-style-type: none"> • 2 dropped out very early on, when asked what were the main factors in their decisions, the answers were; • "Felt isolated and restricted" in voicing their opinion • "Felt uncomfortable in the environment mainly due to cultural issues" • The mix of male and female • New and "other" ethics • Severe MH patients were perceived as intimidating to the 2 OJ researchers who dropped out
AUGUST 2006 5	Formatting questionnaires A & B (+ C)	<ul style="list-style-type: none"> • Meetings revolving around the formatting of questionnaires and what methodology to use • Issues / process relevance and appropriateness of questions • What to include and what not • On reflection it was suggested to omit Questionnaire C as it was repetitive, this was done.
SEPTEMBER 2006 6	Service Users and Providers meeting Pilot interviews Ethics discussed at meetings	<ul style="list-style-type: none"> • The ability to reflect on learning from personal experience of conducting community based research based on feedback from the pilot interviews • Changing the format as a result of pilot interviews • Changing the semantics, in order to not offend anyone, but to get the response we were searching.
OCTOBER 2006 7	Live interviews with users and service providers Transcribing interviews starts Ongoing meetings	<ul style="list-style-type: none"> • Won Ethical approval from UCLAN • Interviewees were former or current clients of TMA from the OJC • Interviews conducted at TMA or users homes • tape recorder equipment used replies were transcribed • Questionnaire B for service providers was initiated • CE Networks meetings were attended
NOVEMBER 2006 8	Meeting with the steering group on a fortnightly basis –	<ul style="list-style-type: none"> • Discussions on replies from participants, in order to get the most information from the questionnaires • Gender, ethical and sensitive cultural issues addressed on how to conduct interviews • Core Q's on sexual identity were seen as highly inappropriate as many OJ respondents might be outraged • Researchers decided to circumvent the issue and not outrage any respondents, but to carefully ask if they were married. • This method of dealing with the issues at hand, assumes that even though one may be married, having a different sexual orientation does not apply. • The OJC does not discuss such intimate issues
DECEMBER 2006 9	Meeting with the research team	<ul style="list-style-type: none"> • Discussing how to approach service providers who should contact whom & how e.g. telephone or email • How many get info on OJC • The researcher's group requested that the transcribers be Gentile and not Jewish for the utmost confidentiality. (Just in case) • This meant we had to start again and literally "trawl

		<p>through the Yellow Pages” to find those nearest and most cost effective.</p> <ul style="list-style-type: none"> • Conducting further interviews • Still recruiting further participants for interview, at random from the OJC telephone book • CE Network meetings attended
<p>JANUARY 2007 10</p>	<p>Conducting interviews</p>	<ul style="list-style-type: none"> • Interviewees who cancelled interviews had to reschedule and organise • More researchers than tape recorders • Make sure that tape recorders were available and working • Each interview had to be coded and dated – checked if interview was clear • All information was burnt onto CD Roms and sent through the post to transcribers • Transcribing replies • Steering Group meeting held • CE Net Network meeting attended
<p>FEBRUARY 2007 11</p>	<p>Analysis Reporting findings conclusions Meeting</p>	<ul style="list-style-type: none"> • Merging information and extrapolating themes A & B as they were identified • Draft 1 report • CE Network meeting attended
<p>MARCH 2007 12</p>		<ul style="list-style-type: none"> • Draft 2 report compiled, pulling all the “threads” together • CE Network meeting attended • Completion

APPENDIX 3, Method of RECRUITMENT

The group	Key Stake Holders	Their role
Steering group	<ul style="list-style-type: none"> • Service providers in the statutory sector the FIS, PCT, MH Trust and local authority • Service providers in the voluntary sector who are in Stamford Hill and are known to TMA through meetings and working partnerships (Orthodox Jewish, just Jewish and secular) • Service users from the TMA mailing lists 	<ul style="list-style-type: none"> • To oversee, support and guide the research team in achieving their aims through the project • To advise the team during the period of research in what would be useful information to the FIS, PCT, MHT and borough • Through the working process to liaise between themselves statutory, voluntary and service user to break down barriers between the sectors at the decision making level (a new experience for most OJ members and service users)
Research Team	<ul style="list-style-type: none"> • Orthodox Jewish and “Just” Jewish Counsellors, therapists and researchers taken from TMA’s “bank” of professionals (over 50 “on the books”) • Local community members and residents who were interested and committed to the project 	<ul style="list-style-type: none"> • To ensure the team members were confidential in their approach to the respondents and the information at hand • To encourage respondents to open up about the issues in question • To keep to their commitment to complete the research as a team (weddings and babies not withstanding)
Interviewees	<ul style="list-style-type: none"> • OJ Service users (the full range from mild and moderate to severe and enduring mental illness) • They were chosen alphabetically from TMA’s internal mailing list • And randomly from the OJ telephone book of Stamford Hill (known colloquially as the <i>Shomer Sabbos</i>, i.e. the book of those who keep the Sabbath) 	<ul style="list-style-type: none"> • Initially from the TMA mailing lists of previous clients • Then from the TMA waiting lists • Eventually randomly from the local OJC telephone book (Shomer Shabbos - Lit “The keepers of the Sabbath”)

APPENDIX 4, KOSHER CATERING

The following are two letters exchanged in relation to lack of Kosher food, a 3rd reply was not sent (too much t In essence TMA was being asked to be responsible for ensuring that Kosher food options and caterers

Talking Matters – Wellbeing Centre

Promoting Stress prevention in the Orthodox Jewish Community
Stamford Hill Library, Portland Avenue, Stamford Hill, London N16 6SB Tel/Fax; 020 8802 9222
E mail; jose@talkingmatters.info www.talkingmatters.info

Ms Alia Syed
Centre for Ethnicity and Health
Institute for Philosophy, Diversity and Health
University of Central Lancashire
Preston PR1 2HE

1.11.06

Dear Alia

UCLAN/NIMHE Community Research programme in Mental Health Re Kosher Food at training days

We hope all is well in the department and that the latest round of community research in not too much of a headache. Regarding the provision or not of Kosher food I think this needs to be clarified so that we all understand the same thing.

As this programme is funded through the government's Delivering Race Equality scheme, I find it incredulous that it is assumed that as an observant Jewish organisation we shall have no objections to being told for the second time in as many months, that UCLAN will not be supplying Kosher lunch, as its not cost effective for the one or two people who require it.

There are several issues here, Delivering Race Equality - the principle & practice and cost effectiveness.

When Talking Matters (TMA) was interviewed for this programme and asked if we had any questions, one of our major concerns was about the catering for the training days. We mentioned that we would require Kosher and we were told this would not be a problem. Indeed, it surely should be *de rigour* alongside Halal or vegetarian?

What has transpired during the training is as follows;

- | | |
|-----------|--|
| Week 1 | I personally dragged several large bags to Kentish Town in order that the orthodox Jewish group have Kosher refreshments. |
| Week 2 | We <i>were</i> presented with "Jewish" food which I'm sure might have been very nice, but indeed was NOT Kosher, as it was not made by an approved Kosher caterer or still in its wrapper which is the only way it can be received. The impression I got from the suppliers was one of "insult" with obviously no understanding that the issue was not personal but of religious practicality. Only then did someone from the university call TMA to find out what we needed and how to go about arranging this. |
| Weeks 3-5 | We <i>did</i> have Kosher food, which was wonderful, although in rather large amounts, so it was shared out among the rest of the group who seemed to relish the opportunity to eat food "Blessed by the Rabbis" |
| Weeks 6-7 | The current situation is that we are now being told that once again UCLAN is not going to provide Kosher food as its not cost effective for one person. |

Although I recognise that cost effectiveness may be an issue, surely DRE is the over riding **policy** here that we the faith and "hard to reach" communities are being lectured about by the university and the government to go out and deliver race equality in our research and work, yet UCLAN is either unable or unwilling to live by the same rules in **practice**. What kind of example is this and how can UCLAN justify this lack of willingness to deliver the policy?

Surely if the will is there, then a way can always be found? ie there is more than one Kosher catering supplier in London, or alternatively why has no-one called us to find out if it's possible to order frozen meals which can be stored and heated on the day? This is how hospitals cater for small numbers of those requiring kosher food. So it would appear no-one has been bothered enough to do this, hence we are therefore being told, no kosher food.

The message this therefore sends out is that observant Jews needs are not as important as the other groups, it doesn't matter about our needs and we'll be happy to sit with a cold sandwich, eating out of a plastic box when everyone else has hot food and a wide variety of choices spread before them. I personally I'm tired of central and local government departments assuming this is OK. It is NOT, as it feels quite ignominious and alienating to sit in the corner like "little Jack Horner". In short it is unacceptable.

I know you will want to answer us *post haste* as this is an obvious case of inequality which I'm sure the University will want to rectify as soon as possible. If TMA does not take a stand, how is it and how will it be for mental health service users who do not have the where withal or capacity to make such a point?

When this issue has been rectified we shall return to the group for training, in the mean time please forward on to us all the notes from the training sessions we shall be missing.

With thanks for your attention

Yours sincerely, Jose Martin (Ms), National Director

were available to UCLAN, rather than UCLAN taking the responsibility for the

I am clearly disappointed to hear that you have withdrawn from the workshops. These are intended to assist you to deliver your project. We will of course make the handouts available, but we do not believe that these are a substitute for attendance. Furthermore, you should be aware that it is a requirement for the award of the University Certificates in Community Research and Community Research and Mental Health that participants attend 75% of the workshops.

Despite all of the above and the considerable hurdles that you have had to go through with regard to ethics, I do know that the research project is coming along very well, that your research team is enjoying the work and that you have a good working relationship with your Support Worker, Imran Mirza. I am delighted and grateful that you have agreed to assist us by hosting a visit by international colleagues from the Czech Republic and the FIS Review team which I hope will be beneficial to all. These are the sort of collaborations that we undertake with our partners to share and build on joint experiences.

I hope the above explains our position and can only apologise for any mistakes we have made in error.

Yours sincerely

Alia Syed
Senior Support Worker – Southern Team

In essence TMA was being asked to be responsible for ensuring that Kosher food was available to UCLAN, rather than UCLAN taking the responsibility for the catering and delivery. This was felt to be the responsibility of the university (administration department) and not that of Talking Matters and certainly did not fit with the over arching priorities of the Delivering Race Equality agenda. One person member of the team commented that "They (UCLAN) couldn't or wouldn't even deliver a Kosher sandwich, so how will they deliver race equality?"

Date: 10th November 2006



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Dear Jose,

Re: Complaint about Provision of Kosher Food at Uclan Workshops

Thank you for your letter of 1st November regarding the above issue.

Over the last 6 years we have worked with over 1,000 people from more than 200 different community organisations, representing many diverse groups including:

- Black and minority ethnic communities
- Faith communities
- Gay and lesbian communities
- Groups of offenders in both community and custodial settings
- Gender specific groups, including women who have been victims of domestic violence and female sex workers
- Drug users
- Mental health service users
- Young people
- White people living on deprived estates
- Older people
- People with disabilities
- Refugees and asylum seekers

The delivery of such a large programme across so many different groups is inevitably complex. While I can appreciate that your own experience of taking part may have fallen short of what you had expected I would like to assure you that we take the individual needs of all our participants very seriously indeed. To this end we have, over the years taken a number of specific steps including:

The organisation of workshops to avoid religious holidays

- The provision of prayer facilities and the provision of appropriate breaks to allow people time to pray
- The delivery of gender specific workshops
- **The provision of a range of specific foods**
- The provision of interpreters
- The provision of be-spoke workshops for young people
- The provision of signers
- The delivery of workshops in locations that take account of transport links
- The provision of special handouts for people with dyslexia and sight difficulties
- The payment of personal carers
- The provision of venues with appropriate access for people with disabilities
- The provision of venues with access to childcare facilities
- The provision of be-spoke workshops for people who cannot travel, such as prisoners

As alluded to above, I can appreciate that all of the above will be of little concern or interest to you if your personal experience fails to measure up to the standards that you would expect. Accordingly I would like to apologise to you for our failures to make adequate provision for you in week 1 and for the mix up in week 2 which resulted in 'Jewish' rather than Kosher food being provided.

I am also delighted that the provision of food for you was 'wonderful' in weeks 3-5.

I note what you say about weeks 6-7 and specifically the point that you make about the fact that someone could have called you to see whether it might have been possible to provide frozen meals which could have been re-heated on the day, or to identify other Kosher catering suppliers in London. However, as I understand it, you were consulted about the arrangements that we proposed to make and, while expressing some reservations about them, did agree to go along with them. Given this I would have hoped that, in the spirit of working together and of partnership, you might have been more pro-active in making these suggestions yourself at the time that we consulted with you.

While cost should not be an over-riding consideration in how we provide for the specific needs of any of the groups with whom we work, it clearly is a factor. We are accountable for how we use the public funds that are made available to us and we are under an obligation to ensure that we achieve value for money in all aspects of this programme. In weeks 6-7 it was not the cost of the food per se that was at issue, but the cost of delivery and, as stated above, we had felt that we had reached an understanding with you about this after our discussions with you.

APPENDIX 5, QUESTIONNAIRES A AND B

QUESTIONNAIRE A

GENERAL WELL- BEING: Experience and Attitudes

We are going to ask you a set of questions regarding mainly emotional and behavioural concerns. We would be grateful if you would focus on two people well known to you. One of them could be your-self and another family-member, friend or community member. Their identity will be strictly anonymous. Kindly tick the box that you think most accurately answers the question. Many thanks indeed for your co-operation and help.

1. Do you know of anyone who has experienced emotional behavioural/psychological problems?

YES
NO

If yes→

What kind of problems has that person experienced?

- a) Overeating
- b) Unable or unwilling to eat.
- c) Reliance on drinking alcohol
- d) Addiction to non-prescribed drugs
- e) Addiction to prescribed drugs
- f) Obsessive/compulsive behaviors (OCD)
- g) Difficulties in sleeping
- h) Pre Menstrual Tension (PMT)
- i) Post Natal Depression (PND)
- j) Any other unspecified behaviors

2. Did this person feel they needed help from others?

YES
NO
Don't know

3. How do you think that the person coped with their difficulties?

- a) Very well
- b) Adequately
- c) Pretended to cope
- d) Did not cope
- e) Seemed to fall apart

4. Was the emotional/behavioural difficulty given a name? (defined)

YES
NO
Don't know

4A. If yes→ What was it?

- a) Overeating
- b) Unable or unwilling to eat.
- c) Reliance on drinking alcohol
- d) Addiction to non-prescribed drugs
- e) Addiction to prescribed drugs
- k) Obsessive/compulsive behaviors (OCD)
- l) Difficulties in sleeping
- m) Pre Menstrual Tension (PMT)
- n) Post Natal Depression (PND)

o) Any other unspecified behaviors

4B. If it was not defined → In your perception, What seemed to be the problem?

- a) Overeating
- b) Unable or unwilling to eat.
- c) Reliance on drinking alcohol
- d) Addiction to non-prescribed drugs
- e) Addiction to prescribed drugs
- f) Obsessive/compulsive behaviors (OCD)
- g) Difficulties in sleeping
- h) Pre Menstrual Tension (PMT)
- i) Post Natal Depression (PND)
- j) Any other unspecified behaviors

5. Who defined the problem ?

- a) A Rabbi
- b) GP.
- c) A Counsellor
- d) Social worker
- e) A psychiatrist/psychologist
- f) a Friend
- g) Other..... Please specify

6. What help was recommended?

- a) Daven (Pray)
- b) Say Tehillim (Psalms)
- c) Visit a Mekubol
- d) Give Tzedokoh
- e) Counselling or Psychotherapy
- f) Medication
- g) Regular outpatient attendance
- h) Hospitalisation
- i) Complementary therapy
- j) Other.....Please specify.

7. What help was available?

- a) Rabbinical guidance
- b) National Health Service: community psychology
- c) Cams (Children mental health service)
- d) Amhs (Adults mental health service)
- e) Emergency psychiatric unit
- f) Social Services.
- g) Support of family and friends
- h) Informal help
- i) Voluntary Organisation
- j) Other..... Please specify.

8. What services or help did the person concerned eventually use?

- a) Giving Tzedokoh (charity money)
- b) Checking Mezuzos (prayer boxes on doors)
- c) Take prescribed medication
- d) Counselling/ Talking Therapy
- e) Alternative medicine
- f) Admission to hospital
- g) Rabbinical advice.
- h) Other.....Please specify.

9. Were there any services offered that were refused or not taken up?

- Yes...
- No
- Do not know

10. What were the reasons given for not taking up services offered ?

- a) Service not available
- b) Person did not wish to avail themselves of the service offered.
- c) It did not suit the individual's life style
- d) It was not culturally religiously appropriate/sensitive
- e) Other.....Please specify.

11. Were the persons' family/friends etc. aware of the emotional/behavioural problems?

- YES
- NO
- Don't know

12. If yes→how do you think they responded?

- a) Sympathetically.
- b) Understanding
- c) Supportive
- d) Wished to help but did not know how best to.
- e) Unsupportive
- f) Antagonistic
- g) Shame
- h) Embarrassment
- i) Fearful
- j) Ostracised the person with these problems.
- k) Other.....Please specify.

13. If not →How did they find out?..... Please specify

14. If the person concerned did not feel able to share the information why do you think this was?

- a) Shame
- b) Embarrassment
- c) Fearful
- d) Ostracised the person with these problems.
- e) Other.....

15. How do you think the wider community would react upon hearing of the person's emotional/behavioural issues?

- a) Sympathetic
- b) Supportive
- c) Dismissive
- d) "It is not my business"
- e) Critical
- f) Blaming
- g) Other

16. As far as you know, how did the individual feel about the services they received?

- a) Very positive
- b) Positive
- c) Indifferent

- d) Negative
- e) Very negative
- f) Other
- g) Service in practice not available
- h) Person did not really want the service offered
- i) The service did not suit the person's lifestyle
- j) The service was not culturally sensitive
- k) Other reason.....Please elaborate.

17. Did the person seek Rabbinical Input?

- YES
- NO
- Don't Know

17a. If yes→ was the advice forth coming?

- YES
- NO
- Don't Know

17b. Was it easy to make an appointment?

- YES
- NO
- Don't Know

17c. Were the symptoms reduced?

- YES
- NO
- Don't Know

17d. Did the individual act upon the advice?

- YES
- NO
- Don't Know

17e. Overall, what was the experience of the Rabbinical help?

.....

18. Did the person seek the help of friends & family?

- YES
- NO
- Don't Know

18a. If yes→ was the advice forth coming?

- YES
- NO
- Don't Know

18b. Were the symptoms reduced?

- YES
- NO
- Don't Know

18c. Did the individual act upon the advice?

- YES

NO
Don't Know

18d. Overall, what was the experience of the help from friends & family?

.....

19. Did the person seek help from a voluntary organisation?

YES
NO
Don't Know

19a. If yes→ was the advise forth coming?

YES
NO
Don't Know

19b. Was it easy to make an appointment?

YES
NO
Don't Know

19c. Were the symptoms reduced?

YES
NO
Don't Know

19d. Did the individual act upon the advice?

YES
NO
Don't Know

19e. Overall, what was the experience of the voluntary help?

.....

20. Did the person seek NHS Input?

YES
NO
Don't Know

20a. If yes→ was the advise forth coming?

YES
NO
Don't Know

20b. Was it easy to make an appointment?

YES
NO
Don't Know

20c. Were the symptoms reduced?

YES
NO
Don't Know

20d. Did the individual act upon the advice?

- YES
- NO
- Don't Know

20e. Overall, what was the experience of the NHS help?

.....

21. If the person used more than one category (Rabbi/friends/family/voluntary/NHS), what was the best service?

- a) Rabbi
- b) Friends & family
- c) Voluntary
- d) NHS

Special Section for Women only:

22. Do you know an individual who suffered from PMT (Pre Menstrual Tension)?

- YES
- NO
- Don't Know

22a. If yes → Did it effect their emotional well being?

- YES
- NO
- Don't Know

23. Do you know an individual who suffered from PMD (Post Natal Depression)?

- YES
- NO
- Don't Know

23a. If yes → Did it effect their emotional well being?

- YES
- NO
- Don't Know

SPECIAL OBSERVATIONS CONCERNING YOUTH (12-19 years)

24. Do you personally know of any youngsters experiencing emotional/behavioural difficulties?

- YES
- NO

24a. If Yes, what were the problems that you have noticed or observed?

- a) Dropping out of school
- b) Antisocial behaviour
- c) Taking non-medicinal drugs
- d) Depression
- e) Anxious behaviour
- f) Obsessive-compulsive behaviour
- g) Hiding the truth
- h) Aggressive behaviour
- Other.....Kindly specify

24b. What was done to help the young person?

- a) Referral to a Rabbi/Mechanech/Mashgiach(Educational figure)
- b) Referral to a GP
- c) Referral to an educational or clinical Psychologist
- d) Referral to an Outpatients Department
- e) Referral to a A&E Hospital Department
- f) Sent abroad.

24c. Who referred them?

- a. Family
- b. Teacher
- c. GP
- d. Self
- e. Do not know

24d. If nothing was done ,why do think it was ignored?

- a) Shame
- b) Stigma
- c) Embarrassment
- d) Denial
- e) Low motivation.
- f) Not sure of what could/should be done.

24e. Was the help offered effective?

- a) Very effective
- b) Effective
- c) Indifferent
- d) Not effective
- e) Highly uneffective

24f. Do you know of any Organisation which can assist such young people?

- YES
- No
- Don't know

24g If yes→ Who is it run by?

PERSONAL ATTITUDES:

25. What do you think the Torah advises in cases of emotional/behavioural difficulties

.....

26. As far as you know or can tell how would you rate the reaction of Community Leaders or Rabbonim?.....

27. Does having an emotional/behavioural problem interfere with being a Frum Jew? (Ultra Orthodox)

- YES
- NO
- Don't Know

28. In your frank opinion, do you think that help/services from OUTSIDE the Orthodox Jewish Community are needed and might be a good idea?

- YES
- NO
- Don't Know

29. Why do you think that such OUTSIDE Services might be a good idea and necessary? Please explain as fully as you can.

.....

30. Is there any other information/experiences that you would like to share with us? Do you know of other people other than the one you spoke about? And would you say that the person you elaborated upon has a typical experience?

.....

31. Would you prefer an orthodox Jewish mental health service?

.....

Why?.....

QUESTIONNAIRE B (for service providers)

1. Do you think you are providing a sufficient and good service to the OJC? How would you describe the mental health services you are providing for the OJC community?

- Unsatisfactory
- Sufficient
- Good

2. Do you think the service is culturally sensitive?

- Yes
- To some degree
- No

3. What do you know about the OJC in terms of their belief system (1-5 answer, nothing, not a lot, some, quite a bit, loads)

- 1
- 2
- 3
- 4
- 5

4. Do you have access to information re the OJC?

- Internet
- Personal contact
- Books
- Indirect contact – for example, through mental health workers from within the community
- No. because we are unable to do so)

5A. Do you have a relationship with any OJ organisation for consultative purposes re mental health (i.e Talking Matters Association or Chizuk)

- Yes,
- No, but would be interested in doing so
- No, because we are unable to do so,
- If not : why?

5B. If you consult with a representative of the OJC regarding service provision, who do you consult with?

6. Do you collect regular monitoring figures in terms of minority communities service take up in the OJC?

- Yes
- No, but would be interested in doing so
- No, because we are unable to do so,

7. What do you think is the prevailing attitude to mental health in the OJC?

- Awareness
- Acceptance
- Fear
- Stigma
- Denial
- or a combination of these.

8. When planning service provision or meetings for minority communities, does the department consider the Sabbath and Jewish High Holydays or not?

Yes
No
Don't know

9. If yes where does the information come from?

Not needed in this form, see 5b.
If not, why not?

10. Do you have any suggestions that would create better service take up

11. Do you have any other suggestions?

.....

APPENDIX 6,

SERVICE USERS MAIN THEMES

Theme 2 of analysis

- 2. Stigma,
- 2.1 Denial,
- 2.2 Fear,
- 2.3 Judgement,
- 2.4 Ways of coping with Stigma
- 2.5 (Not) Sharing the information

2. Stigma

From interviews: 4, 15, 18, 19, 21, 26. 7, 8, 9, 17,5, 11,16, 20, 22, 23, 24, & 25

- **Stigma:** people concerned about their name because of marrying off their children. Mental health issues are "real issues". P 26
- Stigma as a result of people living close and gossip. P26.
- **Secretive approach to illness:** The patient did not tell anyone about their problem. P15
- **Stigma against divorced women.** P 4.
- **Stigma; arranged marriages issues,** her daughters were very worried about the mentally ill brother. The family has a problem every time a shiduch time arrives. P 18.
- **Stigma & Education:** The stigma is a big problem, they need psychiatrists to visit the local Jewish schools and explain about mental disorders.
- Because it is a **small community** and the community is everything one is reliant on the community for **self-worth**. Everybody knows your business, and observing one to see if you are conforming to religious norms. Stigma gets created as a result of not conforming to religious norms. P 19
- Mental health **might be catching**, Stay away from mental health. P 19.
- People **gossip**, this adds to stigmatizing. P21
- Judgemental community. P 21
- The family is hiding the case of the teenage girl in the foster family because "you do **not air out your laundry in public**". P21.
- The community gets scared of anything out of the ordinary and respond by saying: "you should not feel that way" and "do not want to hear more about it".
- **Secretive attitude to mental health:** In Stamford hill you are not allowed to talk, the whole world will find out, they will **shun** you.
- Friends and family **not told because of the Stigma** of Mental Ill Health P20 L 350 – 353
- People told person experiencing mental ill-health has a **physical illness**
- Family thought her mental health problem was like **having the flu** and that it would be short-term and go away. They told people she had pneumonia and that's why in hospital P 016 L 263 – 271, P16 L 278, P16 L 317 /20, P20 L 357 – 360
- Because **woman can't fulfil her role as a mother** P16 L 292 – 267 P016 L 303 – 306
- Affecting marriage prospects of a child P016 L 311 – 313 - P016 L 599 – 602 P20 L 447 453, P20 L 458 – 459 , P20 L 531 – 539 ~ 16)
- Reported emotional problems can be blown out of all proportion and jeopardize finding a suitable marriage partner ~ eg, a minor accident can be blown into a full blown trauma. P23. L 544-553
- If community found out about breakdown, then person would be black listed and the person would feel embarrassed and ashamed P20 L 357 – 360
- Didn't tell anyone because **felt shame** P23 L 381
- Families don't want to **seek help for their children**, so emotional problems get worse P20 L 427 – 430, P20 L 439 – 443
- Person coped well agoraphobia – feels embarrassment and shame upon reflection p23 L 437 – 457

- Counselling services are not taken up because problems are swept under the carpet and people don't know help is available, P24 L 261/2, p24 L 297 – 301

2. 1 Denial

* They did not share their problems because they believed nothing was wrong. Fear of going beneath the surface. P 7;

* Denial by lady with post natal depression of her situation. P5:

* There is a lot of **denial** P 19.

* **Shame and denial:** "I think she is ashamed of her own problem, I do not think she is denying it to herself".

2.2 Fear / Stigma

- Perceptions of mentally ill people as feeling **guilt**, sadness and **shame** because of their disorder. P7:
- People should not be **shunned** by other people and not be labelled. Line 311.
- Mentally ill people, **are different** than people who 'just' have a problem.
- Mental health image will **deter good marriage**. Leads to people not asking for help. P9;
- **Fear of people knowing** about one's mental health problems because of consequences for marriage. P9
- People are **not scared of the disorder** as much as they are scared of the **social reaction**.
- Participant refers to the individual with emotional issues as "It". This language use de- humanise the individual. P5
- People hide it, it is frightening, there is a stigma about it, **it is not well understood**, it is better to keep quiet about it. P5
- **Stigma and hiding:** the information about the illness got out only when things got out of control. "It becomes public without anybody wanting it to be public".
- **Stigma:** people are **frightened**, "mental health might be catching", but at the same time sympathetic". One has to do everything to make them comfortable". Line 490.

2.3 Judgement: Mentally ill people are being judged

- p7: other people are **watching your behaviour**, always choose your words carefully.
- **The Rabbi/Rabbitsen might be judgemental** of your problems too, thus fear of sharing problems with them.
- P8; Accepting people who are different would make a more colourful world.

2.4 Ways of coping with the stigma of emotional problems

* Family **sends depressed children away** from home to stay with **other families**

* **Denial** that there is a problem

* **Family run away** and offer no support

* Others can be judgemental to others through their own fears

* People think they have to be perfect and deny their problems to avoid being rejected by their community and themselves

* People **don't want to associate** with people who have emotional problems because they feel they could be contaminated with that person's weakness'

2.5 (Not) Sharing the information of mental health (related to Stigma)

* **Told only one friend**. Not discussed emotional problems (depression) with wife. **P17**

* **Told no one** cause **denied** problem. **P7**

* Information is not shared by the person because "he is too young". **P9**

* The participant (mother of boy with difficulties) **did tell people** about her problems. **P9:**

* **Will not consult the rabbitsen** for her emotional issues. P8:

Theme 3 of analysis:

3. Understanding of mental health in the community,

- 3.1 Cultural norms,
- 3.2 Perception of mental illness,
- 3.3 Social issues in the OJ community,
- 3.4 Community support in the OJC.

From interview 01, 03, 06, 10, & 14. 7, 8,9, 17,5 4, 15, 18, 19, 21, 26, 11,16, 20, 22, 23, 24, & 25

3. Understanding of mental health in the community,

Theory about why Emotional Problems Happen

- * Happens after emotional trauma
- * Emotional Trauma if not acknowledged has detrimental effect
- * Person's nature and an event, such as the death of a close relative can trigger the depression
- * Way in which children are raised by parents.

Explanations of mental illness causes

*** Causation in the physical:**

- * "Fortunately for me it was a medical problem and I was able to be treated, why it was I do not know". P17: Line 360.
- * Explaining mental health problem as **lack of awareness of god's presence**. P9:
- * Equalizing generalization: everybody has got a problem. P9:
- * High expectations from men to be "talmid chacham" (excel in bible studying) and spirituality can cause problem. "Because he came from a mother who wanted him to be talmid chacham with the torah. P8:
- * Explanation of why diagnosis was not made: denial. "Because in the beginning it was the first time of post natal depression and later on it was swept under the carpet". P5:
- * Family history P11 16 – 17, P011 47 – 49, P011 – L 73 – 75, P20 L 174 – 177
- * Family not accepting his conversion to OJC , P11 18 – 20
- * Current family situation P011 L 37 – 39
- * Build up of tremendous stress on the mind P20 L 119 – 121
- * Marital breakdown & stress = P20 L 421
- * Father died when he was young, mother holocaust survivor P24 L 79 / 82
- * Reason for depression = has a problem in his mind P25 L 53

3.1 Cultural norms/requirements

*** You have to behave in a certain way:**

People are not allowed to be themselves; Nicely, kindly, politely, correctly. Must not be angry! Therefore, everything becomes bottled up until outburst. It is pretence! P7: Line 270.

- You have to be on your best behaviour, cause never know who is watching.
- A belief that you have to belong to somewhere (i.e social group, institution, organization). P9:
- When being mentally ill it is not worthy being a Jew. P9:
- We are much more narrow minded, we are not open to the world. P8:
- Our education and belief made us obsessed about cleanliness but we are also asked to be hospitable and socialize and the two are hard to combine. P8:
- You need to think of other people, not to be self centred as a Jew. P8:

Effect on Family members as a result of Mental Ill Health

- * Family learn from the experience – makes them stronger people P011 L 61 – 63.
- * Causes Trauma to children growing up as a result of difficult behaviour P011 L 198 – 193
- * Prognosis ~ Not going to get better P011 – L 67 – 68 Friends and Family shocked P20 L 112 – 115 P20 L 162 – 163 P20 L 167 – 168
- * Family saw woman as lazy until they realised it was part of her illness, P016 L 224 – 236
- * Precipitated acknowledge of emotional problems in other family members p20 L 179 – 194
- * Family found the money to pay for counselling for the man even though didn't have it, P20 L 253
- * Had to make decisions of mans behalf about what was going to happen to him. P20 L 148 – 151, P20 L 155 – 158

3.2 Perception of mental illness:

- * Helpless, has not choice, can not decide upon anything. p5:
- * **No control:** Mental illness seen as a condition in which the patient is very fearful of not being in control.

OJC Beliefs of mental health from 11, 16, 20, 22, 23, 24, & 25

- * No common beliefs in OJC about emotional problems – have to experience problems to understand them P011 L368 – 370
- * Beliefs in OJC suffocate spiritual development L 324 P22 L 324
- * OJC believes that emotional problems are a stigma P22 L 481
- * Don't need to have services for OJC provided by the OJC but services can be accessed in the Jewish Chronicle P25 295 – 298 P25 L 204 305,
- * But , People can find OJC services in the Jewish Chronicle Newspaper, P25 337 – 340
- * OJC believe that you sweep emotional problems under the carpet Push it to the back. N25 L 589 P25 L 596 – 601

Disadvantages of Talking Therapy

- * **OJC prize conformity** and so Counselling is mistrusted because independent thought may result from counselling P016 L 664 – 666, P 016 L 672 – 675, P 16 L 709 – 720
- * **Rabbi's are afraid that counselling will lead to an independent mind** and people will take less notice of Rabbi's. P016 735 - 732
- * Saw a specialised counsellor because normal counsellor was not effective, Initial counselling was provided by TMA but was not effective – see above p 20 L 327 – 336
- * Cognitive Therapy brings up issues he is finding hard to deal with and is not willing to continue to P24 L 22/25

Perceptions of the Way Mental Health Affects Behaviour

- * Poor Relationships with others P11 L 19 – 20
- * Forceful behaviour over others P11 L 24 – 26
- * Lack of trust P011 L 36 – 38
- * Stays on his own P11 – L 53 – 55.
- * Can't care for the needs of others P016 L 39 – 44, P016 L 129 – 134, P016 L 129 – 134, P016 – L 38 – 39, P016 L 36 – 38, P20 L 126 – 129
- * Unusual communication with others P11 L 59 – 61
- * Denial of problem P22 L 59 -61 P22 L 85 – 87, p22 L243, P22 L 220 – 222, P24 L 39 / 42
- * Lying, avoidance, blame, projection. P22 126
- * They became very...it was all internalised. L235
- * Deceptions to cover up illness Sometimes it involved deception, taking taxis, pretending to be late when he found it very difficult to get from A to B. L 374
- * Benefits from the attention they receive as a result of being depressed and this attention gives him no will to deal with depression, P24 L 12 – 15
- * Needs to be reminded to attend cognitive therapy sessions P24 L 58 / 9
- * Does not make use of cognitive therapy sessions because does not engage in the process & cancels half the appointments offered to him P24 L 149 P24 66 – 71
- * Does not take on responsibility in his life P24 82 – 85
- * Suffers physical ailments as a way of seeking attention P24 L 92 – 97, P24 L 104 – 106
- * Obsessions and anger p24 L112
- * Unable to care for himself physically P24 L119 – 126
- * Behaviour is weird and unbalanced - P24L126 – 131
- * Can phone respondent up to 6 times a day p24 L 137 – 143
- * Can't set up a care plan, formally or informally because does not engage in the process P24 162 – 166
- * Won't work p24 L221
- * Lack of personal motivation P16 L36
- * Man broke down suddenly & behaviour was not normal P20 L 285, P20 L 16 – 20, P20 L 24 – 26, P20 L 289
- * Difficulty walking in the street, difficulty travelling P23 L12, Doesn't like walking in the street, large open spaces, can't cope with Stamford Hill crossroads. P23 L 12 – 19
- * Mood swings ~ L 11/12 ~ Checks himself into St Anne's L 14, P25 L51 – 54, P25 L 133, P25 L 142, P25 L255
- * Varying levels of mobility L32
- * Always calling NHS and an ambulance L39/40
- * Has Asthma and uses a ventilator L 41 / 42
- * Doesn't get treated seriously by GP p25 L 229 – 231
- * Doesn't mind who he tells about his illnesses L P25 L 357
- * Can't relate well to others P25 L 61 – 65
- * Wasted his intellectual ability P25 L23 – 25
- * Seems to be constantly ill with something P25 On every pill going P25L22

3.3 Social issues in the OJ community.

- **Marriage is related to labelling** and one's actions have implications to his family. Guilt for status of your family. P19
- **Pressures to be financially successful but also not to go to university.** Inadequate secular education and desperate need to be financially successful. P19.

- Because **mixing of sexes is frowned upon**, you grow up not really speaking to the other sex. When encountering emotional problems sex can also be an escape. This might be with random people or masturbation. P19
- **Escape** as a result of mental distress can be to **drugs or alcohol**. **Alcohol is readily available** in the Jewish community. P19
- Huge emotional stress can be caused from **insolvable identity situation**. Alienation from both the community and the outside non-Jewish world. P19
- **Marriage**: Marriage in the OJ community is jeopardized due to the aggressive rebellious behaviour of a teenager girl. P21.

3.4 Community support in the OJC

- did not exist in her case. She went to rov and rebitsen, they were friends of the beating husband so did not do anything to help. The wider community does not care, each looks after one self. P4.
- **Jewish phone line** was not helpful as it was closed when she felt suicidal.
- Wished that more advice will be around in the community for **divorced ladies**. In terms of financial advise.

Support of Family and friends

- * Only told those he could trust P11, L 272 – 274
- * Only told those who wanted to listen P011 L 278 – 279
- * Families need to listen to family members who have problems – it means so much_P011 L289 – 294
- * Husbands view of Wife's mental health ~ Denial there is a problem
P16 L126 – 129, P016 L 138 – 143, p16 L 162 – 164, P016 – L 218 – 219
- * Family on the whole supportive P 16 L 469 – 474 P23 L395 – 414,
- * Delay in seeking help – accepted help when they realised they had no choice P016 L 208 – 210
- * Some people were insensitive and made cruel remarks when they found out but support outweighed the lack of it through insensitive remarks based on ignorance P23 L 423 / 4, P23 L 432 – 435
- * Intelligent people tend to be more supportive than emotional people towards friends and families with depression and mental illness P24 L 343 – 346
- * Family are supportive, but hard to take him seriously, feel he cries wolf a lot. Is supportive on a scale of three l427 P25 L 414
- * Family support = (1) P23 L395 – 414
- * Friends and Family Support Family supportive on a scale of 8, Friends on a scale of 4 L389 – 396

Community attitude towards mental health - support/no support

- * Helpful: the school has worked with him for 3.5 years. P9:
- * Help was non existent; the husband only looked after the wife 'officially'. P5:
- * Very unhelpful: the surrounding has blocked any access to individual with mental issues. P5:
- * Surrounding of individual was not accepting help for themselves not for the individual. P5:

Theme 4 of analysis:

- 4. Jewish belief system & mental health,**
- 4.1 What does the torah say / Being a Frum Jew with Mental Health.**
- 4.2 Rabbis / Rebitsen.**
- 4.3 Well-being & the torah**
- 4.4 Social issues derived from belief**

4. Jewish belief system and mental health

- * Jewish way of life is to emphasise the positive. P26
- * Not to judge other people, and not to fear.
- * Obstacles make one strong, and can inspire other people.
- * Not to judge other people, and not to fear. P15
- * Obstacles make one strong, and can inspire other people. P 15

The rov/rebitsen will direct you to medical channel in a reliable way. P 15

Belief system: the belief in god makes her stronger, and helps her to withstand the stigma. She says to herself that shiduchs are made in heaven and so it does not matter what prejudice opinions people have about mental health. P18

- * Pray as help mechanism: “everyday I pray to hashem to help me keep my head above water” p 18.
- * **The Holocaust**: affects fears of participant who is second generation. Related to not trusting non Jewish psychiatrists. P18
- * The torah about mental health: “We must care for every Jew and non Jew and love everybody as much”. P18.
- * Genetic attribution as cause of mental health
- * Mental health fears are not from the torah books, they are fro the culture. P 19.
Belief and mental health:
- * Counselling was put in this world for a reason, people need to take a step back and look at any issues. P 21.
- * What the torah says about mental health is that “**shlom bayit**”, (**peaceful home where people are at harmony with each other**) is the most important thing so that g-d can rest in the house. P21
- * Without peace in the house there is not chance because g-d is guarding the house.p21
- * The **mezuzahs on the door** (Jewish ornament with a religious scroll containing a pray) guaranty no problems, and when problems do occur the mezuzah. P21.

4.1 What does the torah say/Being a Frum Jew with Mental Health.

What does the Torah Say about mental health

- * Torah says it's **a sin to be unhappy** but people can't help it P011 L386 – 389
- * Torah says we have an obligation **to guard ones health** ~ mental illness as an illness has to be treated P016 L 735 – 737
- * The Torah says **pray for the person who has a mental health** problem P20 543 – 545
- * Torah doesn't say anything about emotional health, Torah is a collection of stories to teach right and wrong p22 336 340
- * The torah doesn't help people to articulate themselves on a personal level P22 L 348 – 349
- * Other religions have tools that Jewish people can use that work P22 L 362 – 366
- * Torah says you **can't develop spiritually** and become close to Hashem unless you find **joy inside yourself** and to find the joy, often involves healing yourself of hurt.
- * **Learning to love yourself** so you can **love others** is important. One way to do this is to find the positive in yourself, P23 L 561 /3, P23 L 563 / 5, P23 L 565 / 8
- * Requirement of the Torah is **to improve one's behavioural** and mental health, P23 L 569 – 570
- * Torah Acknowledges the **existence of depression** P24 L 488 – 490
- * Speak about your problems because if you are depressed, you can't pray.
- * **Be happy** and you have no problems
- * **Can't be Frum Jew** if have special **educational needs**

Does Having mental health problems interfere with being a frum jew ?

- * Can't go to shool every Shabbat ~ L393
- * Pressure to be happy at Shabbat is stressful and distressing, P011 L 397 – 401
- * Functioning as a Frum Jew with mental health problems ~ see the whole of page 14
- * Mental Health Problems affect persons' ability to be a frum Jew because they can't carry out the rituals and engage in learning L 554 -559_p20 L 554 – 559
- * Subject feels bad about his situation because he can't daven P24 L150 – 155
- * Respondent doesn't feel emotional problems or mental ill health interfere with being a frum jew L 497 – 498
- * Well being involves being joyful and connected to Hashem P23 596 / 597

4.2 Rabbis/ Rabbitsen

- * The rabbis do not want to know about problems like abuse of children. P19.
- * If you have a problem with a young person you do not go to the Rabbi because they are not broad minded enough. They do not understand the word 'molest'. P21
- * The rabbis are very busy, are doing their best. (Kate Lowenthal, Psychology researcher, participant in statutory part of research).
- * **Rov involvement in mental health:** damage limitation exercise.

"The Rov would encourage to do more mitzvahs...If really bad, speak to a psychotherapist. Advise about what books to read and what to do. Damage limitation exercise. Their primary concern is the religious observant of the the young person, not happiness". P5.

Reb/Rebitsen as referrals to OJ counselling

- * Rebitsen told wife to go to TMA. P17
- * Would not go to rov with mental health issues, only for cash or kitchen problems, P9

Would not consult a Rebtisin or Rev

- Loss of image in the eye of the Rev / Rebetsim
- Follow the Torah and all will be well.

What Does Rev / Reb Say ?

- * Rev & Reb can refer to people who can help P11 L 406 – 410
- * Rev / Reb would not know how to help L 585 – 590. Training would be good, but do they have the time?
- * Rov & Rebbestin don't offer effective help, a) Refer to lies in the torah P22 L 363,
- * Don't know how to help p22 L374
- * Make inappropriate Jokes because they don't know how to articulate the emotional side of life ~ P22 L 374 P22 L 379 – 382
- * Would not necessarily go to Rov / Reb – would go to person who could help., P23 L 578 / 582
- * If went to Rov / Reb for help, they would say to daven and spend time alone with Hashem, which is similar to cog therapy. P23 L 588 /590
- * Rov / Reb is supportive, P24 L 507 /9, P24. L 516 / 517
- * Would consult with Rev / Reb, alive or dead and others who are not 'qualified' but who have something to offer Some Rev/ Reb might shun you if you have an emotional problem & label you P25 L 633 – 634, P25 L 640

4.3 Well being and Torah

- * The torah wants us to be **happy** and if we are not mentally stable we cannot be happy. (Therefore if we are mentally ill we do not do what the torah wants). P9
- * The light is not shining on people with mental health problems.
- * When being mentally ill it is not worthy being a Jew.
- * Being happy and not to worry
- * Do the right thing
- * Well functioning
- * The more religious you are the happier you are
- * Look after yourself
- * Being organised and in control
- * Often gives advice which creates tension in relationships
- * Teach children to live life well and to value life
- * Feel for your fellow friend
- * Many people are not aware of what the torah says

* If you don't follow the torah, you will not be happy

Definition of well being:

- * living a normal life, act normal in public, carry out their duties, self-satisfaction with their achievements.
- * Sense of Well being is feeling healthy and stress free. P11 L 414 and Stress free 418
- * I think I might have said peace of minds, calmness of spirit... P016 L 769
- * Empowerment and choice P016 L 773
- * a sense of wellbeing and control and that control brings wellbeing. P016 777
- * Functioning well on many levels P20 L 612 – 614
- * Physical, mental, emotional, social, financial and spiritual. All, you can't have one without the other, wellbeing. Balance. L403 – 404
- * Well being involves being joyful and connected to Hashem P23 596 / 597
- * Definition of Well Being = being able to cope, doesn't mean not suffering. P24 L 523, P24 530 – 533

4.4 Social issues derived from belief system:

- **Marriage is related to labelling** and one's actions have implications to his family. Guilt for status of your family. P19
- **Pressures to be financially successful but also not to go to university.** Inadequate secular education and desperate need to be financially successful. P19.
- Because **mixing of sexes is frowned upon**, you grow up not really speaking to the other sex. When encountering emotional problems sex can also be an escape. This might be with random people or masturbation. P19
- **Escape** as a result of mental distress can be to **drugs or alcohol. Alcohol is readily available** in the Jewish community. P19
- Huge emotional stress can be caused from **insolvable identity situation**. Alienation from both the community and the outside non-Jewish world. P19
- **Marriage:** Marriage in the OJ community is jeopardized due to the aggressive rebellious behaviour of a teenager girl. P21.

Theme 5 of analysis:

5. Recommendation

5.1 Needs for education & raised awareness.

5.2 Improvement to services

5. Recommendation/wishes of participants *from interviews 4, 15, 18, 19, 21, 26*

- * **To train more psychotherapists** within the community.
- * To have **sheltered housing**,
- * **Young people:** need educational psychologists and social workers to be part time available in schools and to educate headmasters about emotional problems. P15
- * **Increase funding for Therapy** ~ Make it **affordable** P16 L 747 – 749
- * Have a roving school / **educational psychologist** that was trusted by the OJC to especially help **young people**, P016 L 747 753, P016 &58 – 759
- * Good services are provided, but the level needs to be increased and people need to be seen a.s.a.p. to prevent family breakdown, P24 L 252, L 346 – 351

5.1 Need for Education *from interviews 01, 03, 06, 10, & 14.*

- * Educate people about the nature of emotional problems and how they manifest.
- * Educate parents about how to be aware of when children experience emotional problems.
- * Advertise counselling services on a regular basis ~ stress confidentiality.

* **Education:** the OJC needs to be better educated about mental health in the same way as they are educated about cholesterol and heart fitness. P15.

* **Understanding of mental health:** people class all different types of mental health issues under the same pot rather than understanding that there are various areas of mental health issues. P 26

* **Education:** The stigma is a big problem, they need psychiatrists to visit the local Jewish schools and explain about mental disorders. P 18

* **Counsellors in schools:** Having counsellors in school like in America would make a positive difference. P 21.

OJC needs to raise consciousness about mental ill health

* **Raising consciousness,** explaining what mental illness means. P16 L 709 P20 L 521 – 525

* it has to be done **top down from the Rabbi's to the community** but there are resistances, P016 735 – 732

* Hold **information days on Mental Health** for Rabbi's and other community leaders run by respected members of the OJC P016 L 742 – 745

* To decrease stigma of mental health – provide more information to the OJC, **particularly school age children**, adulthood is too late, P20 L 368 to 371 P20 L 386 – 387

* Increased education about **domestic violence** makes it easier for people to acknowledge it exists and seek services. This is a cultural change. p22 L 92 – 96, P22 L 108 – 110

* OJC need educating that **untreated depression can lead to mental illness** P24 L 330 – 333

5.3 Improvement of services

* **Statutory Services to become involved** with cases at an **earlier stage** to avoid all the chasing up required to get services when the situation is critical P 016 L 405 – 409

* Family members who **fostered the children should be paid** for their care and the expenses they incur. Payment was delayed probably because there was the view by Statutory services that there are no poor Jews and they look after family in trouble without needing financial support. P 16 L 417 – 426

* **Hospital procedures should be tightened** so that people don't sip through the net P016 L 414 – 417

* **Better advertising of services** so people know where to go for help_P20 L85 – 86, P22 L 85 – 87, P22 L 93 – 110

* **Better explanation** of how **services are offered** P20 – Line 109 – 112, P20 L 275 – 279

* Services for helping families deal with emotional problems are best dealt with **outside the community** because of the stigma related to marriage_20 L 464 – 467

* Need more counselling services and opportunities **for lonely isolated people** to meet with other and talk and improve their emotional health. P20 L616 647

* Improve Services by having lots of **Personal Development Training courses** P22 L 164 – 194

* Need to have better **follow up services** – but this is a resource problem, P23 L 272 – 274

* Not sure what Services are needed in the OJC. **OJC is much more stable emotionally than other communities** because what binds them together is belief in serving ha shem P23 L 310 -337, p23 L 311 – 314, P23 L 329 – 336

* **Regular home visitor** who is not Jewish & non-Jewish Psychotherapist ~ L 178 – 184

* Friends should **stop taking the softly softly approach** and encourage him to take right action if you help him too much, he will come to expect help all the time and the level of commitment is too great P24 L 197 -201. P24 L 209 – 214

Theme 6 of analysis:

6. Jewish versus not Jewish Culture

6.1.1 Jewish : positive: Sensitivity around mental health for the OJ community

From interviews 4,15,18,19,21,26.

* I had **worries** because I need someone who will understand our culture. P9:

* **Misunderstanding of sensitivities as an orthodox Jew:** one health professional unaware of the **dress code** ad was extremely **inappropriate**. Lack of clothing. P26

* **Mental health services:** some families **only trust the orthodox community** and that should be respected,

...on the other hand, people should have the choice to use professional not from the community. P26

* "The **structure where a person comes from** or wants to be in – if that is broken it compounds the problem, so although the emotional problems will be there for all cases (Jewish or non Jewish therapist) **the Jewish therapist can understand that**". p 15

* **Jewish foster families** made patient feel comfortable and **moderate improvement** in his conditioned has occurred. P 18.

* **OJ counsellors can understand** an OJC person, woman, man needs and emotional being better. P9:

* The **OJC has large families**; there are implications to this, **the others do not understand** this. P9:

* **Rejection of non Jewish practitioners:** The attitude towards non Jewish mental health practitioners:

"The part of the soul which is very much helping the mind to to be well, has got to be dealt with strictly orthodox people, otherwise it is rejected".
Line 514.

6.1.2 Jewish negative

* **Jewish therapy and care not successful:** The participant used Chizuk and the patient (son) used Chizuk too, but in both cases the service was not successful, did not seem to enjoy it. Their help was in recommendation to apply for disability benefit allowance. P 18.

6.2 non- Jewish therapies

6.2.1 Positive approach to non Jewish therapy

* ...on the other hand, people should have the choice to use professional not from the community. P26

* Positive point of non-Jewish counsellor is that you **might not be judged**, and things will not go back to community. P19.

6.2.2 Negative approach to non Jewish therapy

* **Use of services:** participant went to a **non-Jewish counsellor, not convinced that the counsellor understood the full meaning of psychological situation** of the patient because within the Jewish religion everything has meaning, living on the edge of the community or tying your shoe laces... p 19

10) Service Providers Culturally Sensitive to Needs of Client

a) Medical staff were culturally sensitive to needs P011 L 212 – 223, P016 L 355 - 363

b) 4) Delay in Statutory Funding Specifically for Woman was delayed through the belief that the OJC can afford to look after itself. P016 L 84 – 88

c) OJC use the fact that they are OJC to manipulate the situation for their own ends by saying that the service providers don't understand the needs of the OJC. P016 L 355 - 363

d) Counselling was provided by OJC and this was culturally acceptable L 256 – 264

e) Psychiatrist & cog therapist were helpful ~ interested in the frum community ~ Religious and cultural needs understood L 108 – 126 and the carers learnt a lot about Judaism, P23 L 108 – 110, P23L 137 – 139, P23 L 138 – 159. P23 L 243 – 244 P23 L 259 – 261

f) Not known if Psychologist understands cultural & religious needs but friends do P24 L 78 / 79

g) Carers understand his cultural needs because he explains things to them L 88 – 108

Theme 7 of analysis: young people

* **Young people** are not involved enough in and their opinions are not taken into consideration. P15

* **Young people:** need educational psychologists and social workers to be part time available in schools and to educate headmasters about emotional problems. P15

* **Young people:** emotional problems are quite wide spread among young people in the community. P19

- Mental health problem among young people need to be recognized for what it is. P19
- Young person might be ostracized socially if they rebel against formalized religion. P19
- Some young people are being beaten or are going through emotional abuse by rabbis. P19.

- The teenager wanted to leave her house and family, thus got put in this sheltered accommodation that is part of the OJ community structure. P21
 - The teenager behaved like a black person, wore jeans and put her family to shame. P21
 - The teenage girl wanted to look cool and fit in with modern girls and thus said she had cancer or was pregnant. (according to the participant. This is not necessarily true). P21
 - The teenage girl moved from a frum school to a Jewish less frum school and than did not want to go to school at all. P21.
 - She had really embarrassed and shamed her family openly so she might be too late to get her relationship back with them. P21
 - **Drugs:** I have found a lot of teenage boys and girls going on drugs. P21
 - * **Drug use:** Teenagers in Stamford hill use: Cocaine, Marijuana, Speed. P21
 - * **Young people: steal** from their parents in order to get drugs. P21
 - Young people who are looking out for trouble are crying out for help. P21
 - Being rebellious is a cry out for help. P21
 - A community centre for boys and girls in teenage age is needed "they need
 - somewhere to get them off the street". P21
 - There are more and more children getting confused with what they want and the parents become desperate. P21
 - Parents are throwing religion down the throat of their children hoping that this will solve their issues, they are not listening. P21
 - Education of young people: backward, no mention of evolution. P21
 - * high expectations: Mental health is so wide spread problem among young people because of too high expectations. "Parents expect more from a child than the child is willing to handle". P21.
- * **Young people need to be listened to** more in the Orthodox Jewish community. No denial, Allow their feelings. P21.

YOUNG PEOPLE

Hard to say how prevalent emotional problems are in young people P16 L 421

There are problems, but simultaneously same and different to the rest of the pop.

- * There are emotional problems in young people, but the way in which these problems manifest are less violent than the general population p 16 L 506 – 508
- * Young People are supported in the OJC compared to other communities P23 L 466 – 469
- * Don't know if young people are consulted about their concerns or what happens to them in general but in my world they are P23 L 523 – 541, p23 L 533 - 537
- * OJC are just as prone as any other community in experiencing Emotional problems ~ Appearances can be deceiving, P016 L587 – 591, P016 647 – 650
- * prevalence of Emotional problems in young people in the OJC = 20% P20 L 421
- * Emotional Problems are very widespread in young people P22 L 252
- * Young people are mostly emotionally stable, only about 3% respondent comes across as not and most problems can be sorted out by talking them through P24 L 395
- * Young people not understood P25 L 483
- * Hackney is a hard neighbourhood, P25 L 4983 – 495
- * If sexual abuse occurs in the OJC, the police are prevented from investigating P25 L 514 525
- * Doesn't know if young people are involved in care plans or whether their concerns are taken seriously. Young people have a lot of temptations from secular society, Involved as far as they are there. It think there is a lot of peer pressure in this community. Again that can work. Participant 25. L 531 – 532, P25 L 538 – 539, P25 L 552 – 559

Reason for Mental Ill Health in Young People / continuation of problem

- * Jewish community is closed ~ P011 L 326 – 327
- * There is much denial about the existence of emotional problems in the OJC, P16 L 548 – 549, P016 L 462 – 463

- * No where for young people to refer themselves to; a school counsellor like in USA may help identify children with emotional problems P016 L 573 – 577, P 016 L 580 – 583
- * Children are raised in a patriarchal way to be obedient to their families and do as they are told and not articulate how they feel; They follow the commandment 'Honour Thy Father and Thy Mother.' p16 – L 611 – 614, P16 L 628 – 631 , p20_L474 – 497
- * Poor diet P22 L 265 – 268
- * Parents have difficulty supporting their children because they are generally in denial there is a problem where their own child is concerned P24 L 422 – 425

How to improve mental health of young people

- * Young People need more access to exercise to help them feel better ~ P011 L 332 -335
- * Young people don't get support when they have emotional problems
P 011 L 340 – 342
- * Young people need to be consulted when they experience physical / emotional problems P011. P22 L 306 – 317
- * Provide jobs and training opportunities for young people ~ not everyone's life is happily focused on learning to avoid poverty, marriage breakdown and a lack of direction in life P 016 – 521 – 531, P16 L 536 – 543
- * Personal development courses for young people – one's in which they are taught to look within at their own internal processes. P22 L 259 – 261
- * Be able to talk about their problems with someone P22 L 262 – 265
- g) Rabbi's need to be able to help more by listening to young people, P22 L 281 – 284
- * Support young people when have emotional crisis p22 L 291 / 301 P22 L297 – 298
- * When young people have problems, they need to be able to talk to someone older and wiser and this is what happens in the community in which I live Young people in my community are cared for P23 L 477, P23 L 501
- * Young people need to be encouraged to talk through their problems; *What they need is to be encouraged to talk to somebody, P24 L404* They need to be encouraged to talk to adults, not friends who can give bad advice. Grandparents can be good. L 405 / 8 P24 L405
- * A good teacher will notice when a child needs support L443 – 446 But, young teachers don't have the life experience of older teachers. Teachers can destroy children through what they say, important thing is not to be so rigid in the way children are treated. P24 L453 – 464, P24 470 – 474
- * Improve things for young people by praying, forget material things, more police p25 L 500 – 501

Outlets for mental health problems for young people.

P7: Young people can have more help.

Young people problem:

P7: **Young people circular problem** Support is given from the same people who caused the problem in the first place.

- p9: young people problems are because of absence of parents. (it causes bullying).

P9; **young people feeling lost.**: if they do not belong to certain organizations or do not do something like their parents.

P8: Child was very closed up.

P5; young people – children of parents with mental health problem. Group therapy to children of mentally ill patients.

*** Young people: Education to teenagers is needed, in particular to children of mentally ill parents.**

* Young people's views are not taken into consideration / supported when they have emotional problems

Service providers - main themes

Cultural issues	Orthodox Jewish Vv Secular services	Stigma
Clash of cultures	OJ need to collaborate	
Lack of cultural awareness	Trust issues (towards non-Jewish services)	Changes to stigma have been made
Over simplification of Community needs	Jewish therapy	

APPENDIX 7, CORE DETAILS

1 Age

Years	Number	%
15 or under	0	0.00
16-18	0	0.00
19-21	1	4.20
22-24	2	8.40
25-29	3	12.60
30-39	1	4.20
40-49	5	21.00
50-59	12	50.00
Total	24	100.00

2 Gender

Gender	Number	%
Male	5	21.00
Female	19	79.00
Total	24	100.00

3 Ethnicity

Ethnicity	Number	%
British	9	21.00
White other	15	79.00
Total	24	100.00

4 Born in UK

Born in UK	Number	%
Yes	12	50
No	12	50
Total	24	100.00

How long lived in UK

Time in UK	Number	%
1-5 years	0	0
6-10 years	0	0
11 years plus	12	50.00
Total	24	100.00

5 Citizenship

Citizenship	Number	%
British	16	67.00
Refugee	0	0.00
Asylum Seeker	0	0.00
Other	8	33.00
Total	24	100.00

6 First language spoken

1 st language	Number	%
English	15	62.50
Yiddish	3	12.50
Hebrew	2	8.33
Other	4*	16.67
Total	24	100.00

* French 2; Spanish 1; Swedish 1

7 Fluent in further languages

Further languages	Number	%
Yes	21*	87.50
No	3	12.50
Total	24	100.00

* Some recorded English as their second language, for the majority it was Yiddish and/or Hebrew, for some it was other European languages

8 Religion

Religion	Number	%
Jewish	24	100.00
Total	24	100.00

9 Sexuality

Sexuality	Number	%
Heterosexual	11	45.83
Not answered	13	54.17
Total	24	100.00

10 Disability

Disability	Number	%
None	17	70.83
Yes	7	29.17
Total	24	100.00