A Study of Mental Health Services provided to and accessed by Jewish Children and Young People (CYP)

A Report undertaken on behalf of the Jewish Leadership Council

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Acknowledgements

First and foremost we would like to thank the parents, young people and professionals who participated in interviews for this research as well as all of those who completed the questionnaire, provided advice and guidance or acted as ‘gatekeepers’ to enable us to access potential interviewees. In particular we would like to acknowledge with thanks that young people and parents with direct, deeply personal, and often very painful experiences to recount were willing to assist us by retelling their stories. The professionalism and in-depth knowledge of those professionals from the NGO/community and education sectors has also been absolutely invaluable in supporting our findings and recommendations.

We are also grateful to the support of the project advisory board who have worked closely with us throughout, and the JLC for commissioning this important study. Finally we’d like to express our immense gratitude to members of the project team Neil Kaye for his patient technical support with survey software and Shaan Knan for his assistance with compiling materials and networking us with diverse organisations at an early stage of this project.

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Executive Summary

Community leaders, education specialists and NGOs, synagogue representatives and community organisations have recognised a developing crisis in mental health amongst CYP in the Jewish community. Coupled with some highly publicised tragedies, this has led to a broad cross-communal consensus on the necessity of developing a sector-wide strategy and mode of working which makes use of the considerable strengths of the community to provide support. Accordingly, this study was commissioned by the Jewish Leadership Council to engage with and consider solutions to tackling the burgeoning crisis in mental health. This study will assess options for the JLC given the existence of available public services, which are cracking under the weight of demand, the opportunities and strengths within current Jewish organisations, as well as the eagerness to develop culturally competent support from within the community for the community.

The **three key objectives** of the study were to:

1. Determine the Jewish communal, secular and statutory organisations providing services in relation to mental health, special educational needs and social care for Jewish youth up to the age of 25 years, primarily in the London Borough of Barnet, but also including services beyond Barnet used by its residents.

2. Ascertain current problems encountered in relation to access to, and adequacy of provision, as well as the referral routes and relationships between statutory services; NGOs and service users.

3. Acquire knowledge of the views of parents/carers, (who may include relatives of potential or actual service users) as well as a sample of education specialists, front-line service providers and young people between the ages of 18-25. Information was obtained from young people who have personal experiences of using mental health services or associated support, as well as those in contact with young people who may require support (for example youth leaders).

Research

The study was conducted through a survey with a variety of organisations, schools and parents and complemented by interviews (18) with parents (7), young people

between 18 and 25 years (5), organisations (4) and schools (2) as well as a focus group with SENCOs and school heads. The survey was sent to 105 individuals in named organisations, including synagogues and religious bodies, who opened it 52 times, although only 28 full responses were received in total from this category. PaJes and NaJOS[1] circulated a request to their members informing them of the survey and schools. The survey was also sent to Jewish Chaplaincies and JSocs. In total education sector based respondents opened the survey 34 times leading to 24 useable responses. Parents opened it 65 times resulting in 45 completed submissions.

Among organisations, 28 fully completed/useable responses were received including 21 specialist charities, 2 synagogues and an over-arching denominational body (Liberal Judaism), 2 statutory sector organisations, and a therapist in private practice. Two large organisations (including one synagogue) sent in two responses from personnel responsible for discrete elements of their provision with responses reflecting differing experiences and roles in relation to support of young people. The majority of organisations only catered for Jewish clientele but 8 covered the whole (Jewish and non-Jewish) population in their area. Responses were received from 17 (11 primary and 6 secondary) schools across different denominations and 6 university chaplains/JSocs, and additionally the central body of the University Jewish chaplaincy. No non-Jewish schools with Jewish assemblies participated in the survey. Forty Six parents responded to the survey, the vast majority of whom had children who had experienced mental health issues.

Interviews (18) were conducted with a sample of organisations (4) with additional supplementary verbal comments received from the CEO of a support organisation, parents (7) and schools (2) who had responded to the survey, as well as young people between the age of 18 and 25 years (5) who either had personal experience of mental health difficulties or who were involved in a youth leadership/volunteering role which placed them in contact with peers who may have need of mental health and well-being support. A mini discussion group at a mental health champions' day organised by PaJes opened up a discussion which was continued in a focus group with SENCOs (primary and secondary schools) and secondary schools heads/deputy heads with a lead role in relation to mental health and wellbeing.

Results

All the three groups responding to the survey shared the same views on what were the main issues of concern. Anxiety and depression are noted as being the major problem experienced by young people, a finding which is aligned with literature and research which has repeatedly found these to be the leading mental illnesses experienced by CYP. This was followed by pressure to achieve, bullying, self harm, family breakdown and sexual orientation. In terms of difficulties in accessing services for mental health, 'high thresholds' and long waiting lists emerged as a strong theme

[1] The National Association of Jewish Orthodox Schools (NAJOS) has since Spring 2018 ceased to function as a network.

across all categories. Parents also highlighted the lack of accessible information available to them (and presumably also to young people), as well as stigma and difficulties in encouraging the young person to engage with services. The following sections summarise some of the key points raised by organisations, parents, schools and young people (18-25 years) in dealing with mental health (MH) issues and their relationships with both the statutory sector and with the Jewish community, such as schools and parents, or between parents and the statutory services, Jewish community organisations and schools.

Organisations

There are a diverse range of organisations in the Jewish community offering services in Barnet, some of which operate more widely in London and nationally. The largest category of provision was advice and support for young people (15), specialist advice for mental health (9), specialist advice /support for social care needs or provision such as camps for disabled children. In addition, some respondents provided specialist advice/support for learning difficulties (e.g. Legadel, Norwood) or were single issue organisations dealing with matters such as deafness, PMLD (profound and multiple learning difficulties), LGBTQ+ (sexual orientation) and elements of the curricula key to wellbeing issues such as PSHE/RSE. The most common interventions were: Signposting/Referrals to other agencies (20), holiday schemes (11), youth work (11), family support (10), provision of support for schools for example in relation to mental health or learning disability (10), sports/recreation and social work (6), therapy/ counselling (6), behavioural specialist support (6), mental health workers (6), and school education programmes for mental health awareness (5).

A number of organisations provide both preventative and targeted services. Some are collaborating with schools in offering a continuous presence placed in the school to deal with mental health and well being issues. Several organisations flagged up not just the growing number of cases they saw, but also their increasing complexity. As with parents, organisations too were concerned about the need to recognise the individual situation concerning, for example, the nature of the family (size, single parents).

There is substantial networking between Jewish organisations (referrals in and out) but there could also be more sharing of information between them and better dissemination of what they do to the wider community (see under parents, education and also young people). Some synagogues, particularly those of the Reform denomination, have put considerable resources into advice and well being provision (family support, social work, youth work) and are already working very closely to have wider community discussions on MH than may be found amongst Orthodox communities. This includes a communally funded MH specialist member of staff employed by Reform Judaism.

Parents

Parents highlighted the difficulty of accessing services and lengthy waiting lists. Problems in communicating with, and being heard by, schools were also reported to be a problem, as was obtaining accurate, early diagnoses by CAMHS. The lack of early interventions meant that a situation could easily escalate into a severe mental health problem which schools were not equipped to deal with. Both schools and CAMHS were often felt to offer a 'one size fits all' solution without taking into account the specific characteristics of the particular child and their needs. Some parents eventually found appropriate support after a period of trial and error and often considerable expenditure on private professionals, with some becoming experts through experience in how to navigate the system and obtain appropriate support.

Even where parents knew of Jewish organisations working in the field of mental health and learning disabilities, they did not know a great deal about what specific services these organisations provided or alternatively they made assumptions about what they provided based on their best known services (for example associating Norwood with learning disabilities only). And whilst all groups agreed services were inadequate, many statutory services are also largely hidden, with the overwhelming majority of parents being unaware of their existence. For example, Barnet operates a Special Educational Needs Information Advisory Service, which can help parents in moving children to another school, obtaining an EHCP or speaking with SENCOs. There is also a Barnet Parent Carer Group which includes a working party liaising with CAMHS and another with SENCOs and secondary heads, as well as a group (ADDISS) for ADHD support.

Some parents were concerned about what would happen to their children and the support they would receive in the transition to adulthood at 18 years of age (see also concerns articulated under the schools/education sub-heading as well as young people's responses).

Schools and Universities

Schools have begun to put substantial resources into mental health and well-being resources. Some have incorporated more specialist and targeted services into their education offer, and a number are collaborating with service organisations such as Norwood, Legadel and Jami. This level of provision is easier for the larger secondary schools than smaller primary schools with limited resources. The most common services provided in-house are counselling; mental health education and awareness-raising, occupational and speech and language therapy provision, behavioural specialist services, signposting, educational and learning support, and in-house social work. A selection of schools have run the Heads Up Primary Education Programme and the Stepping Up course available from Norwood. Some respondents also reported making referrals to Jami and agencies dealing with substance abuse. In terms of best practice, some have developed a vigorous policy of a whole school approach to mental health and well-being engagement. These include units of work on mental health,

resilience, self-esteem, confidence, bullying, and body image. These schools have offered staff training and have committed financial and practical resources to support students and their wider family members.

Schools can often find the interface with parents challenging, complaining that parents were wanting (and needing) more education in parenting skills and moreover that there was often an unwillingness to recognise the level of academic abilities of their children. Some parents were felt to lack knowledge of what are or are not normal emotional responses or which indicated emergent mental health issues. Similarly, parents were not infrequently reported to be in denial about either learning disabilities/autism and/or mental health problems. At the same time, pressures from an exam-driven culture meant that less academically achieving children were not always being supported in schools or within the community. It was suggested both by a parent and within the focus group with education professionals that a more vocational 6th form (perhaps offered within a single core school or college) for those children who struggled with the pressure of exams or who might not be particularly academic, could be a good idea. Key issues raised in the focus groups and in interviews with young people were around stigma in acknowledging mental health problems, social media, (particularly in the issues with, and ways in which pupils were able to deal with, engagement with social media - especially among the strictly Orthodox), and the pressures stemming from it in relation to appearance and sexual activity.

In terms of priorities, focus group participants listed the following: training on recognition of mental health concerns (for staff, parents and also young people), better (and more**)** training for all members of the community and in all roles, the need for stronger communal provision and greater sharing of information**.** Participants highlighted that a number of key agencies and organisations from within the Jewish community were well known, respected and widely used. Especially highlighted was Noa Girls (it was noted on several occasions with regret that there is no equivalent for Orthodox boys requiring support) and Norwood, but little mention was made of Jami or Legadel although where these had been used they were regarded favourably. Concern was raised in relation to the gap in provision for 16 to 18 years which CAMHS can be reluctant to support as outside of their core target groups.

Amongst University chaplains who responded to the survey (none were interviewed) the default position is to refer students who are struggling with mental health to university mental health services. However given the crisis in mental health provision amongst universities; long waiting lists for NHS provision and increasing levels of student suicides this strategy is unlikely to adequately fulfil the level of need amongst University students. Further work is required to ascertain the experiences of Jewish university students in relation to mental health need and access to services.

Young People

It was emphasised in all 5 interviews that there was a need for younger, more accessible counsellors and therapists who understood the life pressures experienced

by young people. Provision in universities and schools was considered to be poor. It should however be noted that this age group had left school and in some cases were reflecting back on situations which had changed in schools following the development of greater levels of support services. Statutory services (e.g CAMHS) had only been accessed following crisis – such as suicide attempts or an eating disorder crisis – and (whilst in one case in-patient services were regarded as very helpful) outpatients were generally considered rigid, inflexible and often unduly short-term (or offering short, hurried sessions).

For the three young people who spoke directly about their own mental health difficulties, (leading to hospitalisation in two cases and significant levels of therapeutic input in the third instance) it was strikingly obvious and often repeated, that they had felt let down by the school system. One individual interviewed was essentially expelled (invited to leave) as the school struggled to cope with the consequences of their mental health difficulties. In several cases they noted their parents and their teachers' inability to accept or take seriously that they were struggling. They had all reached a point of crisis before they were able to access professional advice and psychiatric support services. All female respondents reflected on the fact that they were aware of significant levels of unsupported (and in some cases unacknowledged) mental ill-being amongst their peers pertaining to the elements outlined above.

The culture of secrecy and shame which surrounds eating disorders in particular, coupled with the pressures to 'be thin' within the community, can be particularly toxic for young women. It was noted by one interviewee, which resonates with findings from the education elements of the study, that within the Jewish community there are exceptional pressures on a young person to either "be a doctor or marry a doctor." Stepping outside of the accepted norms of social, career, gender, sexual orientation or religious orthodoxy could have profound and negative implications leading to depression, self-harming or suicide ideation.

For young people who are not particularly academically inclined, or who may wish to follow a vocational path or not marry at a certain age, (if this is an expectation within their particular section of the community) the pressures and perceived impact on their family of failing to conform could have devastating mental health consequences. Young people who had direct experience of mental health services spoke about a sense of crisis and despair amongst their peers. Young service users and youth leaders both agree that the level of mental health difficulties within their social circles is dangerously high.

Of the two youth leaders, one spoke of knowing that almost all of their friends had or are seeing therapists, (almost always privately accessed through parental or social networks) whilst the only young man interviewed spoke about the need for greater

suicide awareness within the community and in universities, given the risk to young men in particular. This comment is particularly pertinent given the alarming level of suicides found at some leading universities where there are a high number of Jewish students and variable levels of support services.

There was absolutely minimal knowledge of where and how support could be accessed for young people. Whilst some familiarity existed in relation to Jami this was universally perceived of as being for 'old people' or 'not for young people' and no interviewees were aware that Norwood offers mental health support. The most commonly cited source of support (and the holistic nature of the service was greatly commended and appreciated) within more strictly Orthodox communities, was Noa Girls. It was noted with regret that there was no similar service for boys. Youth leaders indicated that there were clear concerns over the poor quality of training and information they received in relation to recognising or dealing with mental health crises amongst their peers and that there was a major gap in services for young people over the age of 16 years. For those who were at universities, concerns were expressed about waiting lists, quality of provision and level of support available to Jewish youth. Given the comments (see above) by university chaplains that they would almost universally (albeit one Chaplain indicated that they did refer to a Jewish counsellor with whom the chaplaincy/JSoc had a contractual arrangement) refer a student about whom they had concerns to the university counselling services this is indicative of a clear lacuna in provision which needs to be addressed if CYP from the Jewish community are to be supported in relation to their mental health and wellbeing needs.

Suggested Recommendations

As the research highlighted, there is an overall systematic gap in provision across both statutory and voluntary organisations and the recommendations need therefore to be understood within this context.

More detailed recommendations pertaining to discrete group of respondents can be found at the end of each chapter of this report.

Our general recommendations seek to engage with issues that were identified within the course of the research, and propose the following necessary actions:

- Development of universal mental health education in schools. Schools to access evaluated training programmes which can be shared throughout primary and secondary schools.
- Training should include recognition of the different needs and abilities of children so that responses are tailored rather than conform to a one size fits all model.

- Greater information sharing between organisations and the education sector. School staff are often unaware of resources from within the community. A need for clear signposting to occur so that parents and pupils can be directed towards support.
- Clusters of schools working together to share resources. This is particularly relevant to primary schools and small schools with limited resources and no counsellors etc.
- Addressing the gap in provision for 16 to 18 years and transition to adulthood, possibly through developing provision under proposals considered in the 2017 Green Paper “Transforming children and young people’s mental health provision: a Green Paper”.
- Investigation into the mental health needs and experiences of Jewish students at universities to ascertain whether in addition to University provision additional support is required when they are away from home.
- Creation of a website listing all available resources and a helpline from which advice could be sought.
- More regular meetings and interaction between the Jewish community and local authority and statutory services concerning mental health provision for CYP.
- Wider community discussions and education (both across and between denominations) delivered to Rabbinic teams, youth services (including youth groups, camps and sports clubs) and parents as well as young people, and education specialists. Overall there is a need for greater awareness of what constitutes mental health problems or learning difficulties and a need for a concentrated drive to break down the widespread stigma pertaining to these conditions.
- Need for, and awareness of, different approaches for different constituent groups – re: strictly orthodox, mainstream orthodox and reform/liberal.
- A need to train and employ (or refer to) younger counsellors across all sectors of the community and in education, synagogue and broader community settings, who are not perceived of as ‘establishment’ and who are familiar with the stresses, temptations and pressures experienced by young people today.
- A greater role for detached youth workers who can engage with young people on a longitudinal basis in informal settings and monitor wellbeing levels on an individual basis
- Madrachim: a real need for training and awareness raising amongst youth leaders who are only often a few years older than the young people they take 'on tour' to Israel or work with in camps and who are often lacking in awareness of warning signs or unaware of available support services.

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Chapter 1 – Introduction and Literature Review

Children's and Young People's (hereafter CYP) mental health has never been of greater concern or attracted higher profile attention in the UK than in recent years. Indeed a review of the broadsheet press reveals that barely a week passes without the publication of another deeply disturbing media report which illustrates the seriousness of the crisis facing over-stretched service providers, parents, schools and Universities struggling to deal with rising levels of mental illness and 'ill-being' (Busby, 2018; Pells, 2017; Townsend, 2018; Buchan, 2018) amongst CYP who are typically in a state of desperation before they will seek help or acknowledge that they are struggling to cope (Salaheddin & Mason, 2016; Time To Change, 2014).

Whilst concerns are continually being raised at the highest level[2] about the soaring level of the mental crisis facing CYP; impacts of funding cuts and ever-lengthening waiting lists, on the ability to support those experiencing mental health challenges (Townsend, 2018; Royal College of Psychiatrists, 2018), and the long-term social, personal and fiscal costs of poor mental health commencing in childhood (Care Quality Commission, 2017; Weale, 2018), it is clear that mental health problems in children and young people are very common - estimated in 2017 to impact one in ten CYP[3], with newly released data suggesting that as many as one in five children are 'at risk' of developing mental ill-health in later life (GL Assessment, 2018) with figures increasing year on year.

Whilst no more recent figures are available (although these should be released later in 2018) Office for National Statistics (ONS) data from 2004 found that at that time, 3.3% of children had anxiety, 0.9% had depression, 5.8% had conduct disorder, 1.5% had hyperkinetic disorder, and 1.3% had a less common disorder (made up of 0.9% with autism spectrum disorder, 0.3% with an eating disorder, and 0.1% with mutism)[4]. Given clear evidence of increases in mental health problems in the intervening years it can be anticipated that these figures have increased substantially.

Moreover without urgent action to deliver a robust, whole-system approach to tackling the issue and seeking solutions to enhance the wellbeing of CYP 'at risk' of mental illness and poor wellbeing it has been convincingly claimed by leading charities that the situation will deteriorate further in the next few years (Townsend, 2018) leaving a generation in crisis; given that on international measures British CYP are recognised

[2] For example see Parliamentary Debates of 27th November, 2017 "Mental Health: Vulnerable Children" https://hansard.parliament.uk/Lords/2017-11-28/debates/6F615D03-7E1F-4683-A965-DE42A5C1CC7A/MentalHealthCareVulnerableChildren; 6th February 2018 "Children and Young People: Mental Health https://hansard.parliament.uk/Commons/2018-02-06/debates/9706B25B-A032-491D-830B-DE377FA1702D/ChildrenAndYoungPeopleMentalHealth; 8th March, 2018 Mental Health Services: Children and Young People https://hansard.parliament.uk/Commons/2018-03-08/debates/E493D7A7-E06D-4196-BE8A-A6D15056D3FA/MentalHealthServicesChildrenAndYoungPeople

[3] Department of Health/Department for Education (2017) *Transforming Children and Young People's Mental Health Provision: a Green Paper* at p6 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/664855/Transforming_children_and_young_people_s_mental_health_provision.pdf

[4] Dh/DfE Green Paper 2017 op .cit. p6

as having some of the poorest mental and emotional wellbeing of any developed nation in the world (Children's Society 2017; Varkey Foundation, 2017).

It is widely recognised that certain challenging circumstances are closely implicated in the risk of developing mental health difficulties in childhood or adolescence. In particular these include:

- having a parent who experiences mental health issues, is a substance misuser or has been in trouble with the law/is in prison
- bereavement (particularly of a parent, sibling or close relative)
- struggling in school with educational challenges (see further below, and in the discussion drawn from interviews in relation to particular difficulties in identification of learning difficulties which do not meet an obvious 'threshold' for intervention)
- having a long-term physical illness
- parental separation or divorce
- being a refugee or asylum seeker (or a frequent mover)
- experiences of being bullied, sexually; emotionally or physically abused
- having been stigmatised or discriminated against (which can pertain to ethnicity, faith, anti-semitism, appearance or disability status, or as a result of the unacceptability of public acknowledgment of sexual orientation resulting from cultural taboos within the home or cultural setting)
- poverty, accommodation insecurity; overcrowding and homelessness
- being a young carer; having a disabled sibling, or having to take on a high level of adult responsibilities in the home[5]

Inevitably, and despite the wide-spread network of practical communal support available to Jewish families in North West London in particular, Jewish CYP are not immune to these wide-spread pressures which are common to all populations in 21st Century Britain. Recent research (Kofman and Greenfields, 2017) has flagged up that a wide range of Jewish agencies, communal authorities; rabbis and educational specialists have all noted with deep concern the "explosion"[6] in mental health needs of young people in Barnet and neighbouring Boroughs, and the difficulties in achieving appropriate support and rapid access to statutory services for CYP experiencing difficulties; such that there is often a significant decline in wellbeing by the time a child reaches the threshold to receive an assessment or treatment.

Moreover, given the reluctance (which it must be noted is gradually changing) for many members of the Jewish community to openly discuss mental health concerns; or

[5] Compiled from various summary sources e.g. Department of Health/Department for Education (2017) *Transforming Children and Young People's Mental Health Provision: a Green Paper*; Care Quality Commission (2017) *Review of children and young people's mental health services: Phase One supporting documentation: Summary of recent policy and literature* and

[6] Jewish News 25th October 2017 "Massive Increase in Mental Health Issues in Barnet according to New Report" http://jewishnews.timesofisrael.com/massive-increase-in-mental-health-issues-in-barnet-according-to-new-report/

educational and learning difficulties which may impact wellbeing (Cadrenel, 2017; Harpin & Doherty, 2018; JVN, 2018; Weich, 2017; Silberman, 2015) for some groups and individuals within the Jewish community there may be particular complexities to their circumstances which may make recognition and acknowledgement of poor mental health especially difficult (Davis, 2017; Kofman & Greenfields, 2017), leading to major barriers to help-seeking; a theme which emerged strongly within the interviews undertaken within this study (see further below).

The recognition by community leaders, education specialists and NGOs; synagogue representatives and community organisations of a developing crisis in mental health amongst CYP in the Jewish community, coupled with some highly publicised tragedies such as the deaths of pupils at JFS; has led to a broad cross-communal consensus on the necessity of developing a sector-wide strategy and mode of working which makes use of the considerable strengths of the community to support our own. Accordingly, this study was commissioned by the Jewish Leadership Council to engage with, and consider solutions to, tackling the burgeoning crisis in mental health given a combination of public services which are cracking under the weight of demand; and the opportunities and strengths inherent in flexible working across civil society and faith organisations, as well as the eagerness to develop culturally competent support from within the community for the community.

Before presenting the findings of the various elements of this study (see the Methodology section of this report Chapter 2 for an outline of the research process), it is important to briefly contextualise the research within the broader policy and literature context of mental health needs of CYP in the UK.

1.1 Background Policy Documents and Recent Literature

As outlined in the House of Commons Library briefing on CYP mental health (2017), in recognition of the fact that mental health problems which begin in childhood and adolescence can have a lifelong impact on individual and family functioning, there has since 2010 been a significant policy interest in seeking to mitigate the disease burden associated with mental illness. It has been estimated that 50% of adult mental health problems (excluding dementia) commence before the age of fifteen and 75% of mental health conditions occur (even if they are not initially treated) before the age of 18[7].

The Care Quality Commission review of CYP's mental health (2017) reported that in addition to the potentially life-long social and wellbeing cost to individuals and families there are significant fiscal implications associated with mental illness, i.e. those occasioned by health, education and social care services, as well as criminal justice and policing (for example we collected evidence of police involvement in several cases where we interviewed family members who spoke of being in contact with the police when a young person was highly distressed and the police had become involved in taking them to a secure psychiatric unit, or intervening when a child was missing or

[7] House of Commons Library (2017) *Briefing: Children and young people's mental health – policy, CAMHS services, funding and education*
https://researchbriefings.parliament.uk/ResearchBriefing/Summary/CBP-7196

found to be self-harming). Overall it has been estimated that mental health problems across the country cost around £100 billion each year (PSRU/Young minds, 2016)[8] as well as being the primary cause of sickness absence from work or education in the UK. Such is the impact on life-time economic and social wellbeing of a child with mental health difficulties that the Chief Economist of the Bank of England has recently intervened (Weale, 2018) to provide financial evidence to support the argument for supporting counselling within schools, indicating that for every £1 invested in in-school mental health support there is an overall 'social return' of £6.20 delivered through improving the long-term outcomes for each child who receives an intervention. Overall, mental health problems are the largest cause of registered disability amongst the entire population, accounting for 25% of the national burden of ill-health (CQC, 2017).

Eating disorders[9] (particularly amongst young women) which have featured prominently in a number of interviews undertaken for this study are a cause of significant concern to mental health professionals given a widespread cultural acceptability of 'slimness' which means that there may not be recognition that a problem exists until it has taken hold. Moreover, there is a culture of secrecy associated with the condition (which is also gradual in impact) meaning that it can often be hidden by those suffering from the condition until it is severe and obvious. In 2007 the NHS information centre reported 6.4% of adults displayed signs of an eating disorder, noting further that up to 25% of those with eating disorders were male. There has been a recognised increase in rates of diagnosis and treatment of eating disorders in recent years. A freedom of information act enquiry by the Guardian Newspaper (Marsh, 2018) has provided evidence that the number of inpatient admissions following diagnosis of an eating disorder reached a peak of 13,885 in the year to April 2017, an increase from 7,260 in 2010-11, with most such admissions pertaining to young women in their late teens to early 20s.

Anorexia Nervosa has the highest mortality rate of any psychiatric disorder in adolescence and of those who do survive only 50% recover, 30% improve but remain 'at risk', and 20% remain chronically ill often requiring periods of in-patient treatment to stabilise their health. Overall it has been estimated that around 1.6 million people in the UK suffer from eating disorders with the condition often developing in adolescence. Eating disorders are also recognised as running in families meaning that diagnosis

[8] Personal Social Services Research Unit/Young Minds (2016) Youth Mental Health: New Economic Evidence https://www.pssru.ac.uk/pub/5160.pdf

[9] Statistics and research evidence supporting this summary discussion is distilled from several sources, the NHS and websites/databases on Eating Disorders https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2017/05/CYP-ED-Waiting-Times-Statistical-Press-Notice-Q4-2016-17-v1.pdf ; NICE Eating Disorders Briefing Paper (2017): https://www.nice.org.uk/guidance/gid-gs10026/documents/briefing-paper a Guardian Freedom of Information Act request in relation to in patient admissions for eating disorders (Marsh, S. 12th February 2018) https://www.theguardian.com/society/2018/feb/12/eating-disorders-nhs-reports-surge-in-hospital-admissions; the website based 'statistics for journalists' provided by the specialist eating disorder charity 'Beat' https://www.beateatingdisorders.org.uk/media-centre/eating-disorder-statistics; the Priory Clinic (who are the UK's largest provider of independent care for individuals suffering from eating disorders) http://www.priorygroup.com/eating-disorders and the charity Anorexia and Bulimia care http://www.anorexiabulimiacare.org.uk/about/statistics

may be further delayed if parents or other relatives consider 'watching what one eats' or 'keeping trim' is simply part of normal life and do not realise it has become problematic.

Recent evidence has suggested that as many as 8% of women experience Bulimia Nervosa at some stage in their life. The condition can occur at any age, but mainly affects women aged between 16 and 40; generally starting in the late teens. Bulimia can affect children but this is regarded as rare. It is suggested by charities and families (see further Marsh, 2018) that access to specialist eating disorder clinics is highly variable ("a postcode lottery") depending upon where an individual lives with some localities offering minimal services despite NICE guidelines, leading families on occasion to relocate to ensure access to adequate support for CYP.

Overall, it is clear that there is an increasing level of demand for mental health services as well as a rising tide of distress amongst CYP. However despite a general consensus that anxiety, depression and general phobias are the most common forms of mental health issues encountered by practitioners (Mind, 2017[10]; House of Commons Library Briefing, 2018), it is not always easy to quantify precise figures, particularly given that many cases of mental health remain undiagnosed until crisis is reached and such recent data as exists is often not broken down fully by age. A House of Commons Library Briefing on Mental Health (2018)[11] presenting data from 2016, suggested that 1:6 people (combined adults and young people over the age of 16) experienced mental health difficulties which had led to diagnosis (p4) and of those referred for 'talking therapies' those referred from the younger age groups are "less likely to start treatment and less likely to finish a course of treatment" (p.15).

In relation to increased demand for services over recent years, the Health Select Committee of 2014 received evidence which indicated that 89% of respondents to a British Psychological Society survey of mental health providers reported increases in number of CYP accessing services (in some cases noting up to 70% increase in young service users) in the two years prior to the time when the Select Committee sat[12]. In the light of the emerging evidence of a mental health crisis amongst CYP, and in response to widespread professional, media and public concern about young people's mental health a series of Government strategy announcements and policy directives have occurred in short succession in recent years.

For example (under the Coalition Government) in 2011, *No Health without Mental Health*[13] was published, followed in 2014 by *Closing the Gap: priorities for essential*

[10] Mind (2017) online fact-sheet "How Common are Mental Health Problems" https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#.WvLdVe8vzcs

[11] House of Commons Library Briefing Paper Number 6988, (25 April 2018) *Mental health statistics for England: prevalence, services and funding* London TSO https://researchbriefings.parliament.uk/ResearchBriefing/Summary/SN06988

[12] Health Select Committee (2014) Report on children's mental health, London: TSO http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhealth/342/34205.htm#a11

[13] Department of Health (2011), *No Health without Mental Health; A cross-government mental health outcomes strategy for people of all ages* *https://www.gov.uk/government/publications/the-mental-health-strategy-for-england*

change in mental health[14]*;* a joint task force on CYP mental health was convened which reported in March 2015 and subsequently between 2015-17 a series of Government announcements pertaining to funding for delivery of eating disorder services for young people[15] have been delivered.

In February 2016 the *Mental Health Five Year Forward View*[16] was published and the Government committed itself to funding the recommendations within that document with the ambitious aim of expanding access to high-quality mental health care for children and young people by 2021 through an increase in service provision to enable support of at least 35% of those with a diagnosed condition. Further a requirement for local area transformation plans was to clearly provide metrics and measures which outline enhanced provision of services to CYP.

Moreover, the critical role played by schools in early identification and support of mental health for children and young people was emphasised in guidance issued by the Department for Education (DfE) in 2014 and 2015 which focused both on the provision of in-school counselling and best practice in identifying and supporting CYP with mental health difficulties[17]. Specific initiatives included the development of 'School Links'[18] pilot programmes through which, in 22 areas 255 schools and 27 CCGs, were funded to establish named leads to connect up service offer and support between schools and the NHS CYP Mental Health Services. There was also a commitment to continued close working between the Department of Health (DH) and Department of Education (DfE) in this crucial policy area.

In December 2017 a joint DH and DfE Green Paper *Transforming Children and Young People's Mental Health Provision* was published which sought to respond to a tranche of emergent research from multiple sources of evidence which demonstrated that for all the vaunted changes to CYP mental health, policies were seemingly failing to have a substantive impact in reducing waiting times or ensuring that appropriate services were delivered to children in need. Simultaneously an Interdepartmental (DH and DfE) joint inquiry was announced in response to the Government's Green Paper on

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[14] Department of Health (2014) *Closing the gap: priorities for essential change in mental health* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf

[15] See HoC briefing 2017 – footnote 5 above; Care Quality Commision (2017) and the Department of Health/Department for Education (2017) *Transforming Children and Young People's Mental Health Provision: a Green Paper* for further information on the series of previous policy announcements

[16] NHS (2016) Implementing the Five Year Forward View for Mental Health (Chapter 2 Children and Young People) https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf

[17] See further: Department of Health/Department for Education (2017) op.cit. and Department for Education (2016) *Mental health and behaviour in schools Departmental advice for school staff* London: TSO https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/508847/Mental_Health_and_Behaviour_-_advice_for_Schools_160316.pdf

[18] Department for Education (2017) *Mental Health Services and Schools Link Pilots: Evaluation* report London: TSO https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/590242/Evaluation_of_the_MH_services_and_schools_link_pilots-RR.pdf

Transforming children and young people's mental health provision which seeks to examine the measures proposed by the green paper; asking "what resources are allocated to schools, colleges and universities to help deliver support on the front line? What considerations are there regarding placing mental health professionals in schools? What does it offer to ensure pupils and students are making better-informed choices about social media use?"[19] At the time of writing the Inquiry is anticipated to report in 2019.

The Green Paper itself was influenced by significant evidence of systemic failure in meeting the needs of CYP with mental health needs. For example, mapping of NHS waiting lists (Care Quality Commission, 2017) and reviews by specialist agencies such as the Education Policy Institute (Frith, 2017) shockingly identified that as many as one in four children referred by schools for specialist mental health services were refused support as they did not meet the threshold for intervention, and that a 'postcode lottery' of waiting times existed for those CYP whose mental health was severe enough for a referral to specialist child and adolescent mental health services (CAMHS) to be accepted.[20] Perhaps because of this difficulty in accessing CAMHS or appropriate support via GP services (a finding which was clear from our own interviews) the BMA had reported in 2016 that the number of young people aged under 18 attending A&E because of a psychiatric condition had more than doubled between 2010 and 2015. Despite the difficulties in being seen as 'severe' enough to warrant access to CAMHS support even if a referral was made, referrals to the service had increased by 64% between 2012/13 and 2014/15.

Moreover, for those CYP requiring an in-patient bed, psychiatrists were reported as having considerable difficulty in locating CYP beds in mental health units which meant highly vulnerable young people waiting for days until a bed was available or being admitted to units sometimes hundreds of miles from home, friends and family[21]. Importantly, in terms of supporting vulnerable young people below the age of 16, the BMA (2016 News Update[22]) indicated that the Clinical Quality Commission has indicated nationally over 20 per cent of localities (33/152 local authorities) do not have 'place of safety' facilities which can provide beds to under-16s leading to enhanced isolation for children at a time of crisis. Four London Authorities: Brent, Harrow (both with substantial Jewish populations), Hillingdon, and Kensington and Chelsea were highlighted in the CQC report as not accepting any under 16s in specialist units within their Boroughs (BMA, 2016 News Update op. cit).

A dramatic increase in self-harming (particularly amongst girls) has been particularly highlighted as a concern amongst adolescents, with a Royal College of Psychiatrists

[19] https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2017/transforming-young-peoples-mental-health-provision-inquiry-17-19/

[20] Frith, E (2017) *Access and waiting times in children and young people's mental health services* London: EPI available at: https://epi.org.uk/publications-and-research/access-waiting-times-children-young-peoples-mental-health-services/

[21] British Medical Association (2016) *Children and young people's mental health* London: BMA

[22] https://www.bma.org.uk/news/2014/april/crisis-revealed-in-under-16s-mental-healthcare

survey of March 2015[23] indicating that 25% of young people they saw had (by self-report) self-harmed on at least one occasion, most commonly by 'cutting'. It must be of deep concern given the prevalence of reports of self-harm identified in our interviews that a study reported in the British Medical Journal (Morgan et. al., 2017) found that there had been a 68% increase in self-harm among girls aged 13-16 between 2011 and 2014. Given that referrals for CAMHS and specialist services varied significantly by postcode, with lower referrals made in more socially deprived areas although incidents of self-harm were considerably higher in such localities, it is highly likely that many children participating in this form of behaviour are not receiving referrals for psychological support (a finding borne out by interview evidence in this study where young people and some parents indicated that they were aware of the prevalence of such behaviour amongst CYP, in some cases without treatment being sought).

Overall, children and adolescents who harmed themselves were (Morgan et al, 2017) approximately nine times more likely to die unnaturally during follow-up, with especially noticeable increases in risks of suicide and fatal acute alcohol or drug poisoning; indicating just how critically important it is to be alert to the risk of exacerbation of self-harming behaviours and development of suicide ideation over time.

It is particularly noteworthy – and this was an issue identified by some respondents to Kofman and Greenfields (2017) as well as within responses received to the current study – that CYP who identify as LGBT+ have been highlighted as particularly at risk of suffering mental illness often as a result of discrimination or stigma (Green Paper, 2017 p7,16). Given the strong taboos on identifying as LGBT+ in some parts of the Jewish community, it may be posited that some young people within the community may experience particular risks of poor mental health and specific barriers to seeking help resulting from fear of stigma if their sexual orientation became known.

As we explore within subsequent sections of this report a number of respondents raised concerns over how to access support for CYP with learning difficulties who may not always meet the criteria to access statutory services or whose learning difficulties were difficult to diagnosis. The Mental Health Foundation states (undated online resource[24]) that for children and adolescents with learning difficulties, the prevalence rate of a diagnosable psychiatric disorder is 36%, compared with 8% of those who did not have a learning disability.

Even amongst those children who do not have clearly defined learning disabilities (for example not identified as being within the autistic spectrum or with another recognised/diagnosable learning difficulty) but who struggle in school, there are clear concerns that their mental health may suffer. Watson (2018) writing in the Times Education Supplement and reflecting on the GA Assessment large-scale study of 850,000 seven to fourteen year olds notes the growing body of evidence which links

[23] Cited at p2 of the BMA report detailed under footnote 13: Royal College of Psychiatrists (2015) *Managing self-harm in young people*. England: Royal College of Psychiatrists

[24] Mental Health Foundation (undated) *Learning disability statistics: mental health problems* https://www.mentalhealth.org.uk/learning-disabilities/help-information/learning-disability-statistics-/187699

children's attitudes towards school and perceptions of their own ability to learn to wellbeing and mental health. Busby (2018) reporting on the GA Assessment study stated that over one in 20 children (6 per cent) were found to exhibit extremely poor attitudes to their learning and have very low self-regard, making them especially vulnerable to mental illness. Reflecting on this finding in the same article, the Director of the National Association of Special Educational Needs commented that "for children and young people in schools, the accountability agenda means there is increasing pressure on teachers and therefore on pupils to achieve more" whilst there are reduced resources in schools and less access to external support services such as CAMHS.

Given the intense concentration on academic ability and achievement which emerged time and again within this study as common to the Jewish community (and indeed proved to be a source of pressure for some young people interviewed), it is perhaps unsurprising that less 'academically able' children within the community may experience significant 'ill-being' if they and their families fail to engage with, celebrate and support them in non-academic career choices (see further discussion on findings from the education survey, interviews and focus group).

Whilst much of the focus in extant literature is on CYP under the age of 18, amongst young people aged between 18 and 25 there is also greatly increased concern pertaining to well-being and mental health (Thorley, 2017). Following a spate of suicides in universities, higher education establishments have sought to develop a focused response on how best to support young people who are often away from home for the first time; may be experimenting with substance use or entering sexual and emotional relationships; and who are also potentially struggling with loneliness; academic pressures and previously undiagnosed mental health needs. Universities UK in their 2018 response to the Green Paper[25] summarise the main evidence in relation to university students' mental health noting that despite limited high-quality data, students appear to have increasing rates of mental ill health and that there are particular concerns about the prevalence of suicidal and self-harming behaviour in the student population. In a study undertaken by the Institute of Public Policy Research (Thorley, 2017), more than 15,000 first-year students disclosed a mental health condition in 2015; nearly five times the number in 2006, while student suicide deaths rose by 79 per cent for the same period reaching 134 in 2015.

Discontinuation of university courses as a result of mental health problems have also been noted as increasing to 'record levels'; whilst in some elite institutions clusters of student suicides are noted in fairly short time frames (Financial Times, 2018). The Times Higher Education Supplement has recently noted with alarm that the suicide rate of UK students has now overtaken the suicide rate of young people in the general population for the first time ever, given that higher education (and in turn better long-term economic prospects) has traditionally been regarded as offering some protective factors in relation to completed suicide or suicide ideation. Young women students

[25] Universities UK (2018) *uuk response to transforming and children young people's mental health green paper* London UUK at p5 http://www.universitiesuk.ac.uk/policy-and-analysis/reports/Documents/2018/uuk-response-transforming-children-young-people-mental-health-green-paper.pdf

were found to be almost 20 per cent more at risk of suicide in 2016 compared with women in the general population, with 51 female students committing suicide in that year, compared with 22 in 2012 (Times Higher, 2018[26])

In the light of these deeply concerning multiple sources of data indicating the risk of premature morbidity and mortality amongst CYP, the December 2018 Green Paper has set out a radical approach to supporting CYP's mental health with additional funding guaranteed to meet (at least some) associated costs. In essence the core to the vision promoted by the Green Paper is to ensure that there is a multi-agency and holistic approach to mental health which engages pupils, students and staff across the educational system (in schools and colleges) alongside families and communities. Each educational establishment will be required to have a designated lead for mental health in place by 2025 who will be trained and responsible for the 'whole school approach' to mental health. The mental health lead (MHL) will be responsible for overseeing school provision provided to pupils with mental health problems; assisting staff to spot pupils who show signs of mental health problems and offering advice to staff about mental health, as well as leading on referring CYP to specialist services as required. Further, they will be expected to continue to update their knowledge through access to funded training to enable them to cascade knowledge through the school or college setting and develop a whole institution approach to CYP's wellbeing. The emphasis on developing awareness and access to interventions from primary school upwards is a long-overdue recognition of the call by the Place To Be (Children's Mental Health Week, 2016) for support for primary age children. The Place to Be and collaborators have urged the need for such embedded support and counselling in primary schools given that 20% of under 11 year olds experience mental health issues at some point and the increasing evidence of panic attacks, depression and anxiety experienced by even some very young children attending nurseries (Pells, 2017).

Whilst not fully developed in the Green Paper, there is an expectation that 'mental health support teams' will be trained staff linked to groups of schools and colleges who are able to offer both one to one and group help to young people with mild to moderate mental health issues e.g. anxiety, low mood and behavioural difficulties and who will also act as a bridge to more specialist mental health services when higher levels of intervention are required.

Importantly there is also a pledge to reduce the time from referral to treatment in CAMHS with pilot areas where new mental health support teams are in place attempting to reduce this to 4 weeks or less for CYP requiring very urgent assistance; although as highlighted by Campbell (2017) austerity measures and cuts mean that no short-term targets have been set, such as to ensure that this occurs in the near future, a theme reiterated by Javed Khan, the CEO of Barnado's who warns (Townsend, 2018) that many children are currently only receiving help if they are self-harming or attempt to commit suicide.

[26] Times Higher *UK student suicide rate 'rises by 56 per cent in 10 years'* 12th April 2018 https://www.timeshighereducation.com/news/uk-student-suicide-rate-rises-56-cent-10-years

In recognition of the risks experienced by young people in universities and indeed out of education, it is anticipated that “national partnerships” will be developed to seek to improve mental health services for young people aged 16 to 25, for example through exploring how universities, colleges and health services can collaborate to enhance provision as well as an enhanced focus on the negative impacts of social media on CYP wellbeing – a theme which again was prominent in the findings of our study. Finally, the Green Paper also stresses the need to work with families to provide information and support where there is a risk that CYP have, or are developing, mental health difficulties, including through the development of parenting programmes (a theme which has also emerged in some interviews with parents undertaken within this study).

Whilst it is difficult at this stage to be able to anticipate how the Green Paper will be operationalised, Javed Khan, Barnado’s CEO suggests (Townsend, 2018) that there is need for radical and rapid action to meet the shortfall in provision, given that civil society is struggling to meet the needs of CYP as a result of cutbacks to commissioned services. Noting that Barnado’s has had to exit 1,033 contracts in the past year as a result of local authority reduction in funding, Khan suggests however that a more collaborative tendering approach between civil society and the state could go far to meeting the needs of vulnerable CYP - an approach which could be particularly attractive within the Jewish NGO and education sector, given the highly developed networks already in existence which could potentially enable more rapid and effective in-reach and intervention than currently exists when statutory services are constrained by less flexible modes of delivery, high demand and funding constraints.

1.2 The Jewish Context: service access and design of mental health services

Within this short discussion on policy and literature pertaining to CYP mental health and learning difficulties, it is worth highlighting some specific challenges and situations which are particular to the Jewish (and in some cases other religiously observant) communities. Some comments apply to our observations, findings and knowledge of the Jewish community generally, whilst others pertain to some specific sections of the community.

It is important to recognise that within a number of responses (survey data and also interviews) which we have analysed, particularly in relation to respondents who are members of (or who work closely with) the strictly Orthodox/Haredi community, there is a distinctly articulated approach and set of concerns in relation to supporting CYP which vary from responses supplied by the wider Jewish communities. Accordingly – and this has been well recognised in Israel in seeking to develop culturally appropriate mental health services – it is important to not presume that a single model of service delivery (“one size fits all”) will prove accessible in terms of providing access to support in cases of mental health challenges.

Moreover not only young people but also parents/carers may have unmet mental health needs which are impacting on the wellbeing of a family (it was noted by one ‘professional’ interviewee for example that they were aware of a child with a potential eating disorder having a mother who displayed symptoms of just such a condition but

who refused to acknowledge concerns over the child's health or reflect upon how this may have impacted their daughter). Similarly, depression or anxiety which first occurs in childhood or adolescence may be associated with family stressors (outlined above, as commonly associated with risk of mental illness amongst CYP) such as shared caring and highly gendered responsibilities in large families; having a sibling with physical, learning or mental health difficulties; anxiety over sexual or gender orientation which may be associated with non-compatibility with Jewish identity, or (as flagged up within interviews and discussions with education specialists and parents) a young person feeling stressed as a result of expectations over academic achievement. This latter theme also emerged in the earlier Kofman and Greenfields study of 2017 when it was highlighted by educational support services (in particular Legadel) that in schools where learning – particularly for boys - involved both intensive English and Hebrew study, a child struggling to work in one language would potentially also be falling behind in the other. The current study has found that in some strongly academic schools children of both genders who failed to achieve consistently high grades feel stigmatised or marked out from their peers, or that they were letting down their family.

As has been mapped in an earlier piece of work (Kofman and Greenfields, 2017) there is also a particular concern from a number of members of the strictly Orthodox/Haredi community that without co-design and delivery of services by and for members of the their community which take account of particular sensibilities and needs (as outlined further in the discussions pertaining to findings), mental health provision targeted at mainstream communities and less observant Jewish populations (even when delivered by mainstream Jewish agencies) may not be utilised or accessible to Haredi CYP and their families.

Recent research by Davis (2017) has highlighted that for Haredi women there are particular challenges to acknowledging that mental health issues (their own, as well as that of spouses of children) exist within a household, and this theme certainly emerged in some interviews in relation to concerns over marriage prospects of children as well as the stigma of acknowledging to teachers or schools that a CYP was struggling with mental health. Similarly, evidence from the USA suggests a high level of eating disorders amongst strictly Orthodox communities, associated in part with the desirability of appearing slim to make a good Shidduch as well as a complicated cultural relationship with food (Gorden, 2015). Whilst there is a recognition of the value of services provided by specialist agencies such as Norwood and Kisharon in relation to diagnosed learning difficulties (see also Kofman and Greenfields, 2017) some strictly Orthodox families may also find it difficult to access services provided by an agency regarded as more 'mainstream Jewish', which is not necessarily regarded as observant enough to fully understand the needs and cultural requirements of some community members. In particular Shor & Aivhod (2011) in an important paper discuss how in Israel, particular models of psychiatric rehabilitation for male Haredim with severe mental health problems based within Beit Midrash have proved effective in enabling outreach to communities who would not necessarily otherwise seek support or who would fail to engage with services on offer, whilst Hebrew University also offers programmes of education (including social work and psychology) targeted at Haredi

who are able to take their learning and professional skills back into their communities. Scope therefore exists in the UK to consider specialist training – perhaps initially delivered to leading communal figures such as strictly Orthodox Rabbis and Rebbetzin - to enhance knowledge of common mental health issues and open discussion within communities where particular taboos may exist in relation to acknowledging difficulties.

Indeed regardless of the degree of religious observance of an individual CYP or their family, the clear communal structures and degree of cohesive contact between members of the community and existence of well stablished support networks suggest that a roll out of a programme of education and open discussion (beyond a one-off or annual Mental Health Shabbat[27]) are required in all communal settings.

In relation to learning difficulties (all sections of the community), for some families – particularly where there is a family tradition of academic achievement or professional occupations - there may be stigma (or reluctance to accept a diagnosis) associated with being advised that that a child has (or should be screened for) conditions such as autism, a point highlighted in the award-winning text by Steve Silberman who outlines both the familial tendencies to 'neuro-diverse' conditions and the wide range of symptoms across the autistic spectrum, as well as the long-lasting and negative impact of some older theories of autism which 'blamed' parents and associated 'toxic parenting' with the risk of a child having the condition. As discussed in the section on findings from 'educational' specialists, even where a non diagnosable learning difficulty exists and a child is simply not particularly academically inclined, this can also been seen as stigmatising, with some parents actively preferring to seek a 'socially acceptable' learning difficulty diagnosis for a child as a way of explaining their levels of achievement, which may in turn create more pressures on a CYP who may not feel valued for themselves alone, triggering mental health issues.

In considering transferability of international concepts, there has been some cutting-edge research and practice ongoing in Israel which is worthy of further exploration to see how this can be adapted to support Jewish CYP (and their families) with mental health difficulties within the UK. For example (as noted above), consideration of development of culturally oriented 'support-education' programmes delivered in partnership with and through Seminaries and Yeshivas and for strictly Orthodox community members have proved successful in supporting individuals with severe mental health issues who are not accessing mainstream services (Shor & Aivhod, 2011) whilst the international (single-gender) 'Soteria House' model (Whitaker, 2018 and Shipley, 2017)[28] offers a 'paradigm shift' in treatment of young people who are experiencing severe mental health such as psychotic episodes, as well as providing support and education to parents and family members who are concerned that a 'first

[27] http://www.headonuk.org/ Jami (Annual Mental Health Shabbat website); Rabbi Epstein interviewed for the Jewish Chronicle on the importance of a Mental Health Shabbat 3/2/17: https://www.thejc.com/rabbi-why-mental-health-shabbat-is-so-important-1.431923

[28] Whitaker (2018) http://www.mentalhealthexcellence.org/soteria-israel-vision-past-blueprint-future/ and Shipley (2017) https://www.jpost.com/Metro/New-concept-Treating-first-time-sufferers-of-mental-breakdowns-505347

time breakdown' may herald a lifetime of psychiatric treatment for a young person, and diminish their life-chances and long-term well-being.

Chapter 2 - Methodology

The methodology was designed to address the following objectives of the study:

1. To determine the Jewish communal, secular and statutory organisations providing services in relation to mental health, special educational needs and social care for Jewish youth up to the age of 25 years primarily in the London Borough of Barnet, but also including services beyond Barnet used by its residents.

2. To ascertain current problems encountered in relation to access to, and adequacy of provision, as well as the referral routes and relationships between statutory service providers (for example CAMHS; Children and Family Services supporting CYP with learning difficulties); NGOs and service users.

3. To acquire knowledge of the views of interested parents/carers (who may include relatives of potential or actual service users) as well as a small sample of education specialists, front-line service providers and young people between the ages of 18-25 who have personal experiences of using mental health or associated support, or who are in contact (for example as youth leaders) with young people who may require support.

The coverage of this study is largely restricted to Barnet, which has the largest Jewish population in a local authority (15.2% in the 2011 census) as well as presenting a microcosm of the Jewish community from the liberal to the strictly Orthodox. At the same time we have included neighbouring Boroughs of Brent, Camden, Hackney and Haringey where there is some spill-over, for example schools attended by a significant percentage of Barnet young people from the Jewish community. For youth between the ages of 18 and 25 years, we contacted university chaplaincies/JSocs outside of London which are known to have large numbers of Jewish students.

Table 1: Location of service users/students reported by respondents[29]

	Barnet	**London-wide**	**Other***
Service provider	6 (18%)	6 (18%)	21 (63.5%)
Schools/universities	7 (35%)	2 (10%)	11 (55%)

As can be seen (table 1) a number of service providers and educational establishments delivered services/had students and pupils drawn from a broadly national or regional cohort. By far the largest of these categories pertained to agencies or organisations who provided advice or delivered services throughout a relatively wide area to Jewish (and in some cases non-Jewish) service users, for example

[29] This basic level information was reported on (and in several cases not completed) by a number of respondents who either failed to complete the entire survey and could not be included in full data analysis or who replied to the majority of other questions and were included in analysis. Hence figures for this question do not fully align with the analysed data provided elsewhere in the report.

specialist organisations who networked with UK wide Jewish services around youth provision; or universities with Jewish students drawn from a wide area. A number of respondents accepted CYP from across London and Hertfordshire– for example well-known Jewish schools or synagogues/youth groups, whilst the remainder delivered services only to Barnet residents.

Before commencing the study, **ethical permission** was obtained from the Middlesex University School of Law Ethics Committee and is in compliance with the new General Data Protection Regulation (GDPR) coming into effect on 25 May 2018. In particular the ethical approval received guarantees anonymity to participants and confidentiality in relation to the information they provided.

2.1 Stages and Methods

The study consisted of the following stages and methods:

1. A review of Jewish communal organisations in Barnet providing services for those up to the age of 25 years in relation to mental health, special educational needs and social care as well as general youth activities, such as summer camps etc. Further it included collation of data on umbrella organisations such as educational networks (NAJOS, PaJeS, Union of Jewish Students) and religious bodies (Liberal, Reform, Masorti, US, Federation of Union of Orthodox Hebrew Congregations) which had a broader remit, as well as individual synagogues located in Barnet.

2. A list of Jewish primary and secondary schools attended by children residing in Barnet as well as identification of selected university chaplaincies in institutions with a large Jewish student body.

Following the compilation of the above lists:

3. An online survey tool, Qualtrics (a research software system for collecting and analysing data), was sent to all those listed above, as well as parents contacted via the auspices of certain key agencies with whom we are in contact. In addition to responses to set questions, the system also allows for respondents to provide additional free-text detailed information, for example on services provided, and on their views and experiences e.g. about quality of services, waiting lists and access to services.

   The survey covered the following topics:

a) Name of Provider/Role (e.g. parent; SENCO etc.)

b) Geographical area covered by service/school

c) Service descriptor

d) Referrers in (e.g. parents, schools, GPs etc.) and outward referrals (CAMHS, other orgs etc.)

e) Percentage of referrals out and to whom – whether services provided in-house by organisations and schools/universities

f) Number of children/adolescents provided for (snapshot) by the following age bands; 3-6yrs, 7-11yrs, 12-14yrs, 15-17yrs, 18-25yrs

g) Waiting list for services (if any)

h) What kinds of problems have been encountered and areas of concern – e.g. eating disorders, self-harm, substance abuse, online abuse, domestic violence, familial related mental health issues; concerns over gender identity/sexuality associated with mental health difficulties; school/social media issues - including sexting, bullying, school problems, general anxiety re media 'overload', and space for 'other' responses.

j) Difficulties encountered in accessing additional services e.g. high thresholds, problems in state or private provision, observations of limited capacity, perceived gaps in a pathway, lack of cultural awareness, lack of choices, limited/inappropriate portal for information.

k) Other information which the respondent wishes to provide – text-boxes for qualitative materials.

Following the initial analysis of the survey, it was decided to send a set of supplementary questions to schools. These were intended to probe more deeply into types of services and training which respondent schools provide for pupils and staff. We asked:

1. Please can you provide addition information in relation to the types of therapy/counselling which are available or provided within the school (where relevant) e.g. psycho-dynamic; Cognitive Behaviour Therapy (CBT); play therapy etc.?
2. Please can you advise on the type of qualifications or training possessed by the staff member or person offering counselling/support – e.g. qualified counsellor; educational psychologist etc.
3. What type of training is currently provided to teachers/staff in relation to mental health awareness and supporting children and young people (CYP) experiencing stress or mental health issues.
4. What type of training would be most helpful to you in terms of equipping your staff with additional skills (where needed) in relation to supporting CYP mental health and wellbeing within your school.

However only 2 schools responded to this request for additional information (information provided within Chapter 5 survey responses Educational Services).

A separate questionnaire, based on sections f to k of the above survey, was sent to parents who were largely recruited through organisations such as Jami, Legadel, Noa Girls and Norwood (with whom we have had prior contact in relation to the earlier 2017 study) as well as by word of mouth.

- Eighteen interviews were conducted with parents, school heads, specialist service providers and young people (aged 18-25) who had either experienced mental health problems themselves or were in a position, (e.g. as youth leaders), to have encountered such difficulties amongst CYP with whom they have worked.

- A mini-discussion group was held by a member of the Advisory Board at a PaJES' Schools Mental Health day. This yielded comments from three primary school SENCOs which helped to shape approaches to the focus group (below)

- A focus group with SENCOs, Pastoral Managers, Heads/Deputy Heads from 2 primary and 4 secondary schools was conducted to drill down further into themes which emerged both from the surveys and the mini-discussion group at the mental health and wellbeing event.

2.2 Responses to the Survey

The survey was sent to 105 individuals in named organisations, including synagogues and religious bodies, who opened it 52 times although only 28 (useable) responses were received in total from this category. PaJes and NaJOS[30] circulated a request to their members informing them of the survey.

Qualtrics records how many times the questionnaire was opened but not whether the same respondent opened it on more than one occasion. Respondents from schools and universities opened the survey 34 times leading to 24 useable responses. Parents opened it 65 times resulting in 45 completed submissions.

2.3 Service Providers and Youth Groups

28 fully completed/useable responses were received including 21 specialist charities, 2 synagogues and one denominational body, 2 statutory sector organisations, and a therapist in private practice. These organisations/agencies provide both specialist advice/support for mental health and social care issues as well as generic support or services for young people, for example, synagogue youth groups and summer camps. In addition, some of the respondents (who have given permission to be named) provided specialist advice and support for learning difficulties for example Norwood and Legadel or were single issue organisations dealing with matters such as LGBTQ+ identities, PSHE/RSE education.

Twenty one out of the twenty nine respondents[31] who responded to a question on whether they *only* provided services to the Jewish community, said this was the case.

2.4 Schools and Universities

Responses were received from 17 (11 primary and 6 secondary) schools across different denominations and 6 university chaplains/JSocs, and additionally the central body of the University Jewish chaplaincy (24 useable responses). The primary

[30] Which has since the Spring of 2018 ceased to function as a network of Orthodox Schools

[31] One survey respondent only completed one or two questions and their questionnaire was therefore excluded from full analysis although they did reply to this question

schools catered for a total of 1260 pupils, of whom 525 were aged 3 to 6 years and 735 from 7 to 11 years. Secondary schools reported having a total of 5045 pupils with 749 of them in the top age band (6th Form) which we gave as 18 to 25 years (to enable responses from universities within this questionnaire). The university chaplaincies accounted for 1550 Jewish students in 6 universities in England and Scotland whilst 4500 students were reported by national University Jewish Chaplaincy.

Few Jewish children attend non-Jewish state schools but there are some private schools with substantial number of Jewish children. None of the 8 non-Jewish schools with Jewish assemblies, to which we sent the survey, answered.

2.5 Parents

45 responses were received from parents, of whom 38 had direct experiences of a child or young person using mental health or social care services.

2.6 Interviews

A total of 18 interviews were conducted. Those parents who filled in the survey were asked if they were willing to be contacted for an interview and in addition we directly contacted a small number of agencies and schools who were known to have particularly pertinent information to share. 27 parents indicated they were willing to be interviewed and 6 of the 7 parents interviewed were recruited through this route. Two head teachers, one from a secondary and the other from a primary school were also interviewed. Young people were recruited through organisations - three girls, who had experienced severe mental health issues and two young people working as youth workers (one male, one female), were interviewed. Though initially agreeing to be interviewed, several young men pulled out of being interviewed at a late stage.

Among parents, the interviews focussed on the specific issues concerning their children's experiences of mental health and wellbeing and their positive and negative encounters with schools and service providers, (ranging from Jewish charities to schools, private provision and the statutory sector). Respondents' children varied in age from primary pupils to teenagers about to transition to adulthood. There were several children diagnosed with ADHD (the most common condition) and autism whilst others had developed suicidal thoughts, sometimes following a family bereavement or as a result reportedly of being prescribed inappropriate or strong medication for a medical condition which produced side effects.

2.7 Mini Discussion Group

A mini-discussion group convened by a member of the JLC advisory board took place during a PaJeS Mental Health event. This consisted of a short focus group to explore services delivered in house by three primary schools, and core issues of concern to the SENCOs who participated in the meeting (see further Chapter 6 under the discussion on education services).

2.8 Focus Group

As a result of some difficulties obtaining attendees the focus group took some time to organise. A two-hour focus group was attended by SENCOs, Senior managerial staff (Head and Deputy Head of two schools) and a Pastoral Manager. Attendees came from two primary and four secondary schools. Discussion ranged widely from communication issues within schools, whole school approaches to mental health support, stigma associated with mental health, parents not wanting to accept issues existed for their children, poor parenting, teachers roles in relation to supporting students who were unwell, and the need for far wider community discussions and awareness of mental health issues. Other topics included the availability of resources, training for staff and parents, and the effects of social media on children and how to handle negative impacts of online activities.

2.9 Analysis

Qualtrics generated data on responses to the survey questions. Each category (service providers, schools, parents) was analysed separately as well as cross referenced. For example, in the survey, there was considerable similarity in the issues of concern impacting young people and difficulties in accessing mental health and well-being services and support (See Table 2).

Data from Qualtrics also generated qualitative information from comments made by respondents in the three groups. Many parents in particular wrote lengthy comments on the difficulties they had encountered in accessing services, and also provided information on what they felt could be best done to improve support for their children's mental health and well-being. These comments were grouped into key themes, which were explored in greater depth in interviews with a selection of parents – identified to include those who were happy with services received; deeply dissatisfied or neutral and including a sample of parents from broadly secular to strictly Orthodox. Young people (as above) were accessed for interview via several key agencies and in addition several core organisations were selected for further in-depth interview.

Interviews were professionally transcribed and thematic analysis then took place in relation to core themes emerging from each set of interviews.

We were particularly interested in comparing the routes into services and insights into the current failings of mental health provision as well as suggested recommendations pertaining to enhanced service delivery from schools, service providers and parents as well as young people's personal experience and perceptions of the above.

2.10 Results

We commence the discussion of findings from the survey and interviews by illustrating the replies to questions asked of all three categories of survey respondents. All respondents they were required to identify the main issues they considered were impacting the mental health and well-being of Jewish Children and Young People (Table 2 and Chart 1) and the main difficulties they considered existed to CYP receiving services and support (Table 3 and Charts 2-3).

We should note that the main health and wellbeing issues identified in the survey as being of concern were shared by all three main groups of respondents as the Tables and Charts below indicate.

Table 2 – Main issues impacting young people

The four most cited categories are highlighted in red

	Parents	Schools/Unis	Services
Eating disorders	17	9	14
Self-harm	20	5	18
Substance abuse	5	4	6
Online abuse	12	4	8
Family-related mental health	13	13	17
Domestic violence	4	5	2
Gender identity/sexuality	8	7	13
Anxiety/depression	33	18	23
School /Uni (achievement/bullying etc.	30	9	19
Social media (cyberbullying, sexting)	15	7	16
Special educational needs, disability	19	9	14
Religious belief, faith identity	5	5	4
Other	3	0	2
Total	184	95	156

Anxiety and depression are noted by all categories of respondent as being the major problem experienced by young people, a finding which is aligned with literature and research which has repeatedly found these to be the leading mental illness experienced by Children and Young People (see literature and policy review Chapter One).

The negative impacts of divorce on a young person, for example leading to the development of eating disorders was mentioned under ‘other’ by one respondent but this theme of parental relationship breakdown/family stressors may have been included under ‘family-related mental health difficulties’ by other respondents who replied to this question. Family breakdown emerged on several occasions in interviews with service providers.

Other issues mentioned in the survey by all three groups were social media, including cyberbullying and sexting, special educational needs and disability and gender identity and sexual orientation.

Figure 1 Main Issues Faced by Young Jewish People

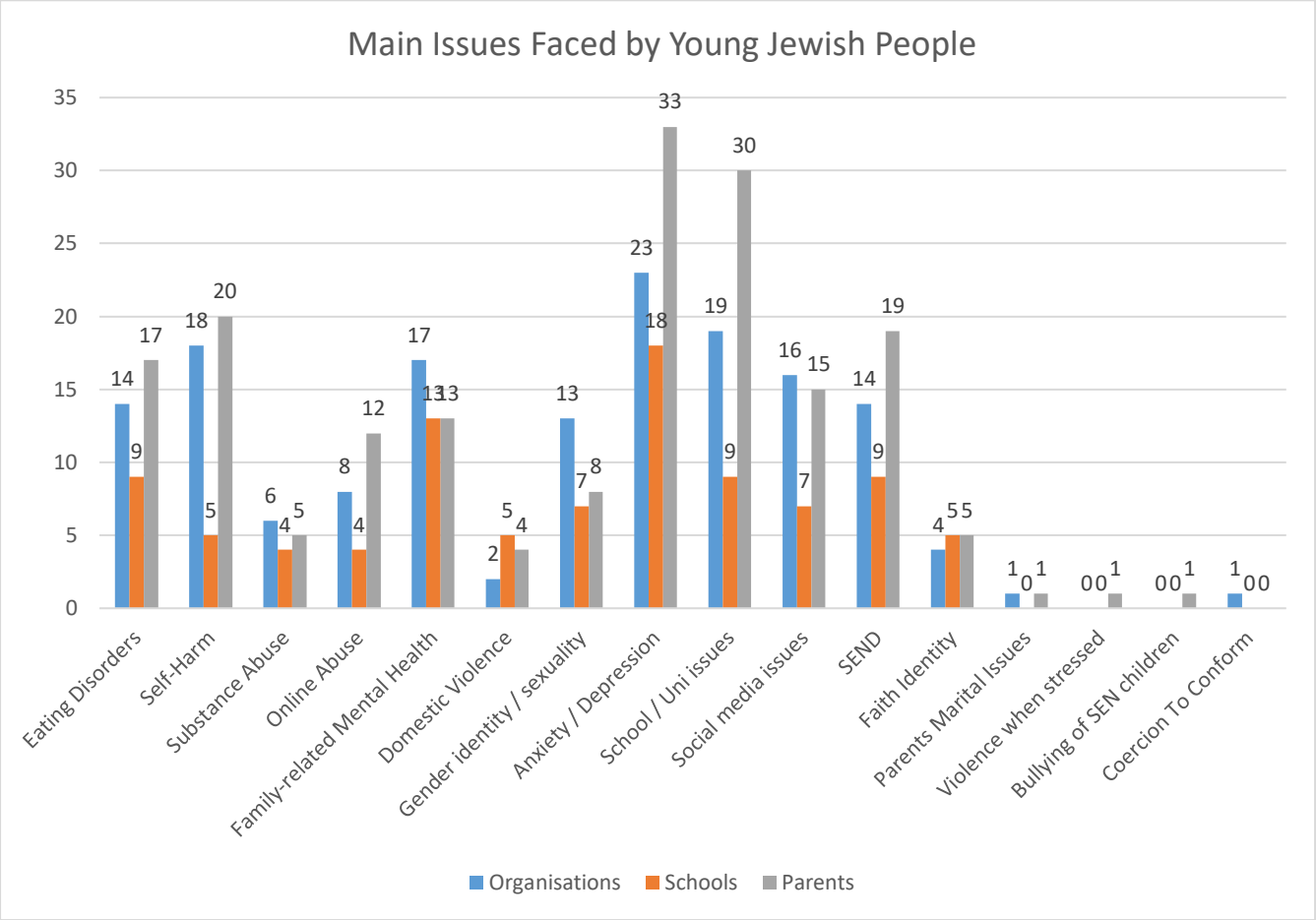


Table 3 Difficulties in accessing (additional) mental health/well- being services and support

Difficulties	P	S/U	Services
High thresholds	8	7	14
Limited capacity/long waiting lists	24	12	14
Delayed applying for/seeking help	5		
Lack of cultural awareness	0	4	4
Expense in accessing services	5	8	10
Willingness of young person to participate	13		
Stigma	11		
Lack of accessible information	18	5	9
Lack of choices	4	2	10
Other		3	8
Total	88	41	69

Unsurprisingly the theme of ‘high thresholds’ and long waiting lists (as indicated above) emerged as a strong theme across all categories, although parents also highlighted the lack of accessible information available to them (and presumably also to young people), as well as stigma and difficulties encouraging the young person to engage with services.

In the following sections of this report we discuss in more detail the experiences, views and recommendations of the above groups (service providers, parents and schools/universities) as well as young people.

Chapter 3 - Service Providers

This category is heterogeneous. Twenty one respondents classified themselves as specialist charities, two as statutory sector agency and 10 as others[32]. These organisations providing specialist advice/support for mental health, social care issues and learning difficulties as well as generic support or services for young people (for example respondents from synagogue youth groups; summer camps, ORT-JUMP etc). The largest category of provision was advice and support for young people (15), specialist advice for mental health (9), specialist advice /support for learning difficulties (8) and specialist advice/support for social care issues (5). In addition some respondents provided specialist advice/support for learning difficulties (e.g. Norwood) or were single issue organisations dealing with matters such deafness, Profound and Multiple Learning Difficulties, LGBTQ+, PSHE/RSE, children with serious illness.

Twenty one of the 28 respondents who completed the survey in full, indicated that they only provide services to the Jewish community. The vast majority of these Jewish specific agencies (70% of the 21 respondents) do not keep records which indicate the break-down of ethnicity or faith of clients.

Overwhelmingly Jewish national youth organisations reported working across the entire spectrum of the community as did specific organisations with a focus on support for particular conditions – e.g. Jami; Norwood; Jewish Deaf Association. However, it is clear from the an earlier study of services for children in Barnet (Kofman and Greenfields, 2017), that such organisations would only in a few circumstances be used by the strictly Orthodox. As an interviewee in this study stated:

> "I think the challenges is that you have the larger voluntary Jewish organisations, who do get some people from the Orthodox Jewish community and, therefore, they're saying, well, we're servicing the whole community. Whereas, there are so many who won't go to those specialised services"

Eight agencies (including over-arching denominational bodies) indicated that they work with specific sectors of the community (e.g. former Charedi who have left the community; two only with Orthodox/Charedi; three with Reform; one Liberal; one Masorti).

Of the eight organisation who work with <u>non-Jewish</u> clients, there were two mental health charities (one of which specialised in supporting young LGBT+ people) two agencies which focus on education; an individual counsellor, a youth mentoring organisation; an organisation which combines educational PSHE advice with generic advice on social care, and a Barnet specific youth agency which works across the Borough supporting young people.

[32] Nb although this figure is greater than the fully useable 28 response received and completely analysed/discussed in the report this is because a slightly higher number of respondents commenced the survey and then failed to complete it after providing very basic information such as whether they only dealt with Jewish clients and/or type of organisation.

While 6 organisations operated within LB Barnet, the majority operated across several boroughs, London-wide or nationally.

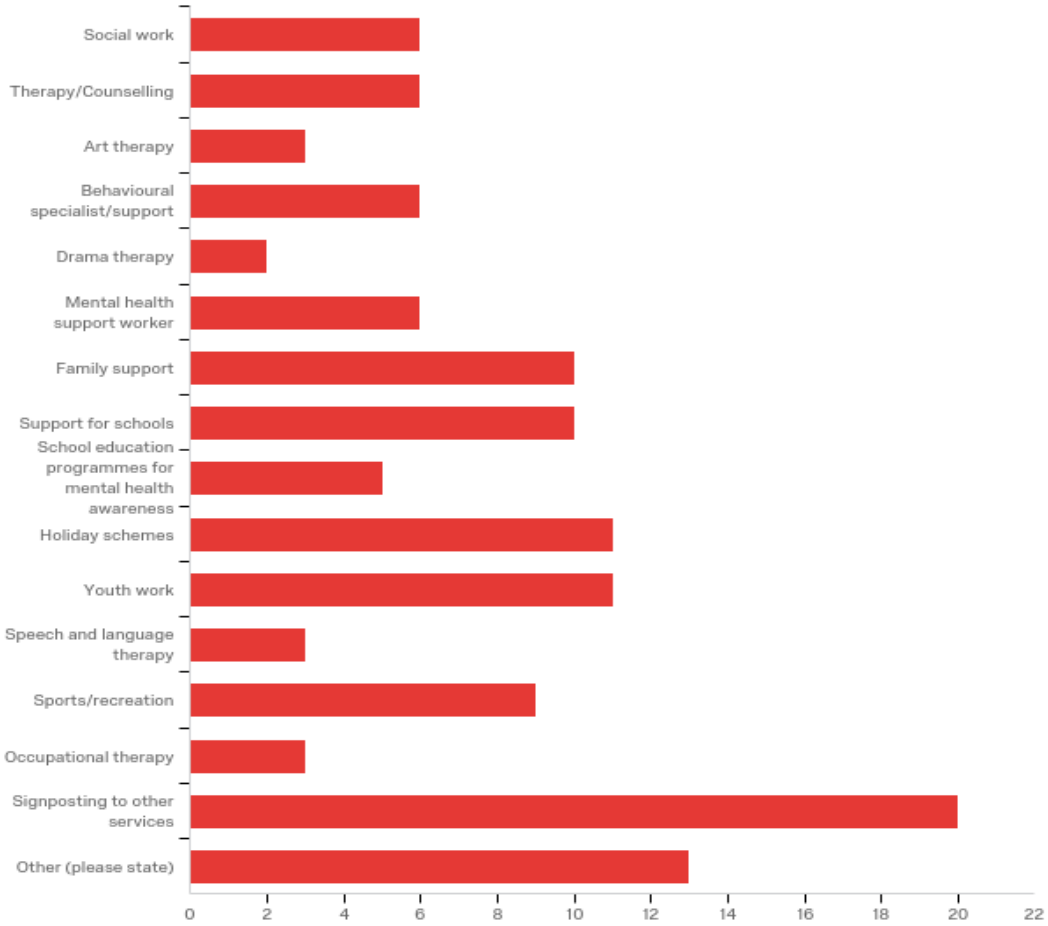
In the following section, we examine services provided in house, the extent to which waiting lists exist for access to services and referrals coming into organisations, and the referrals they make to other agencies.

3.1 Services Provided In-house

Organisations/community groups provide a range of services in-house. The most common responses given for services provided are:

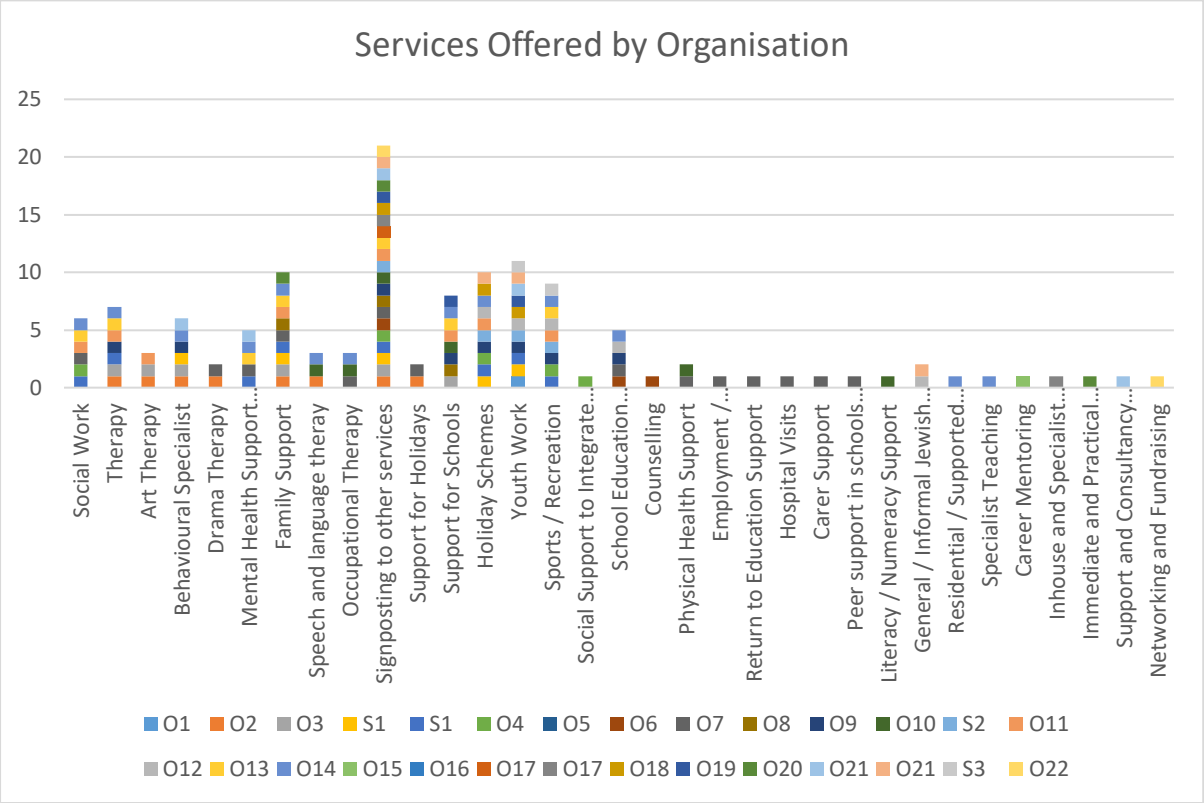
Signposting/Referrals to other agencies (20), holiday schemes (11), youth work (11), family support (10), support for schools (10), sports/recreation and social work (6), therapy counselling (6), behavioural specialist support (6), mental health service delivery (6) and school education programmes for mental health awareness (5). In terms of signposting, it is typically not clear from responses whether direct referrals are made on behalf of a young person, or a young person/their family are simply advised of the existence of other services to which they must self-refer or seek access via a GP for example.

Figure 2 Services Provided In House



As can be seen in Figure 2, signposting is the most common service and this is provided by a range of different organisations. In contrast (see Chart 2) a number of organisations offer specialist services, such as whole family support, therapy or social work whilst support to integrate young people with learning disabilities into education, counselling, employment, career mentoring, peer support in schools, literacy and numeracy support, return to education, specialist teaching, health visits, are only available through single organisations (many delivered by a single very large Jewish agency).

Figure 3 Services Offered by Particular Organisations



O = Organisation S = Synagogue

Thirteen respondents provided information under the category of 'other': this typically referred in more detail to the types of activities they undertook with children, parents and teachers. Some of these services are preventative whilst others are targeted towards specific groups. Some specialise in one category, such as working with schools or people who identify as LGBT+ or are formerly Charedi, whilst others have developed services that combine support for parents, children and whole families.

Example responses include:

- "[we provide] all of the following for young people experiencing mental health difficulties 1. physical health support, 2, employment, volunteering support, 3.

return to education support 4. hospital visiting, 5. Carer support including specific workshops for carers/parents. 6. peer support in schools and in house" [Norwood – who have given permission to be identified within this report][33]

- "Specialist Teaching, Residential/Supported living care, Transition" [Kisharon)
- "We do provide 1-1 counselling support as well but do not regard this as a therapeutic intervention, but rather a more individualised form of mental health education and support" [specialist agency working with Orthodox communities]
- "Social work, Holiday schemes, Sports/recreation, Signposting to other services" [National Jewish youth agency]
- "Physiotherapy; literacy support; numeracy support, Hebrew reading" [small specialist agency working with young people challenged in education]
- "Pastoral support for the whole family" [a Reform synagogue]

It should be noted that the Reform synagogue above offered a wide range of services such as specialist behavioural support, holiday schemes, counselling, social and youth work.

3.2 Waiting Lists

Twenty (71%) of the 28 service providers/individual therapists who responded to the question on whether they had waiting lists for the services they provided said they did not have waiting lists for their services (nb: for a number of these organisations associated with provision of play schemes; generic synagogue youth work etc this would be a largely irrelevant question).

Of the others (8 respondents) who noted that there were waiting lists, 3 organisations - all of whom offered direct services relevant to mental health/social care - provided more information. These included for example a specialist service working with Orthodox/Charedi young women and girls and a leading Jewish service provider working with people with physical/mental health needs etc:

- "We offer a limited amount of psychotherapy for children and young people at reduced cost. There is more demand than we are able to provide"

- "We have a current waiting list of 14 girls wanting to access our service. Once a girl becomes our client she does have access to all parts of our service. As we expand and take on more staff we are able to clear the waiting list but over the last couple of years although we have expanded from 40 girls to 83 we are still really struggling to meet the demand"….."It's huge, and in all the schools.. across the board .. and, what we're finding is that, you'll have a certain amount of girls who really have very high risk, really strong issues, very severe eating

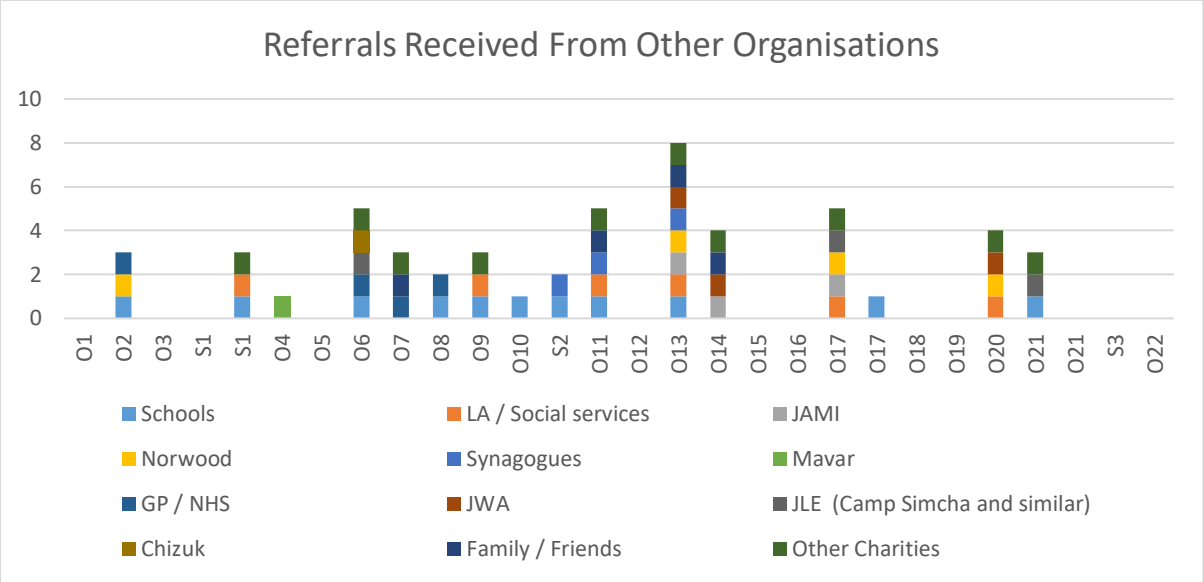
[33] In addition to its core function in social work, Norwood provides a wide range of preventative and targeted services such weekly support groups for parents, Heads Up: training in recognising early signs of mental health and social skills, how to manage anxiety to parents; Stepping Up: for siblings, speech and language therapies to schools, Pyramid Club: for primary schools and information on paying attention to the quiet and withdrawn child, who may be overlooked (see section on parents' responses).

disorders, severe mental health issues. But, what we're seeing is, a massive increase in girls who possibly wouldn't have been affected five, ten, 15 years ago, and are really struggling with their self-harming, their low-level depression, or even high-level depression, suicidal thoughts.

- "Social work services in North West London often have a waiting lists OT/SALT therapies have waiting lists. Counselling [services for] children in schools have long waiting lists (up to 25 children at times)"

Fifteen respondents (55.5% of those who answered this question) reported that they received referrals in from other agencies. All but one of these agencies worked exclusively with the Jewish community and it appears that the extensive community networks which exist across sectors are responsible for these referrals.

Figure 4 Referrals Received In from Other Organisations



O = Organisation S = Synagogue

Figure 4 details the agencies identified by individually numbered respondent organisations (O) and synagogues/overarching denominational bodies (S) as making referrals to our survey respondents..

There is clearly a high degree of referrals occurring between organisations. Paperweight for example (permission given to identify the agency) received 50 referrals from diverse agencies such as Jewish Care, Norwood, JWA, Chai and Gift as well as from local authority officers. Norwood is mentioned by a number of other organisations and, as we have seen, offers both preventative and targeted services.

Others organisations work exclusively in a particular sector such as Legadel (who are willing to be identified in this study) which has 110 children currently on their roll of young people receiving specialist educational support as well as direct interventions

to engage potential learning difficulties before they become entrenched, leading to subsequent educational disengagement and/or have the potential to lead to mental health problems. Some organisations such as Reshet (cross-denominational youth network) do not accept any referrals, as the organisation supports 'educators who are at the chalk face'.

A large number of respondents failed to answer the questions of whether there had been a noticeable increase in referrals to them (and even less replied in terms of numbers of referrals they received), but of those who did (15 responses), 80% (12) said they had experienced a large increases in referrals in the last three years. The reasons given indicated that individuals have become more aware of their services which may be unique, as with Paperweight Trust, or highly regarded within a particular sector e.g. Jami; Reshet, Legadel and specialist agencies working directly and very discreetly with strictly Orthodox communities, etc.

- "X is seen as a safe space for children and families who have not been included elsewhere. This ranges from those with individual needs, physical disability, mental health issues, family bereavement, safeguarding or gender identity". [cross-communal youth organisation]
- "[we have had an] increase in carer referrals from 2016 - 60 referrals 2017 - 105 referrals" [Jewish Mental Health organisation]
- "Y has been operational for nearly three years. The increase in the need for support has been incremental. In 2002 a UJIA Social Welfare department was established in the offer to support to youth movements throughout the community".
- "More parents are approaching us with concerns for young people notably mental health and also LGBTQ concerns. More people are saying CAMHS are more difficult to access and support is not forthcoming - this is also to do with managing expectations" [Reform Synagogue].
- "Increasing awareness in the community. Broadening of our medical criteria. Greater understanding of our criteria amongst professionals in agencies listed above" [Specialist Children's Camp].

More schools were also noted as requesting support, not least private schools (see further under the school responses):

- "More schools are requesting our support, therefore we are having an increase in numbers. Additionally each school is identifying more children with needs, particularly private schools who are unable to access services from the NHS as they will not come in and support private schools despite the children needing help" [Legadel]

In turn 19 of the 27 respondents who replied to the question on referrals 'out' [71% of respondents to this element of the survey] stated that they referred young people to a range of other services.

Figure 5 Referrals Out to Other Organisations

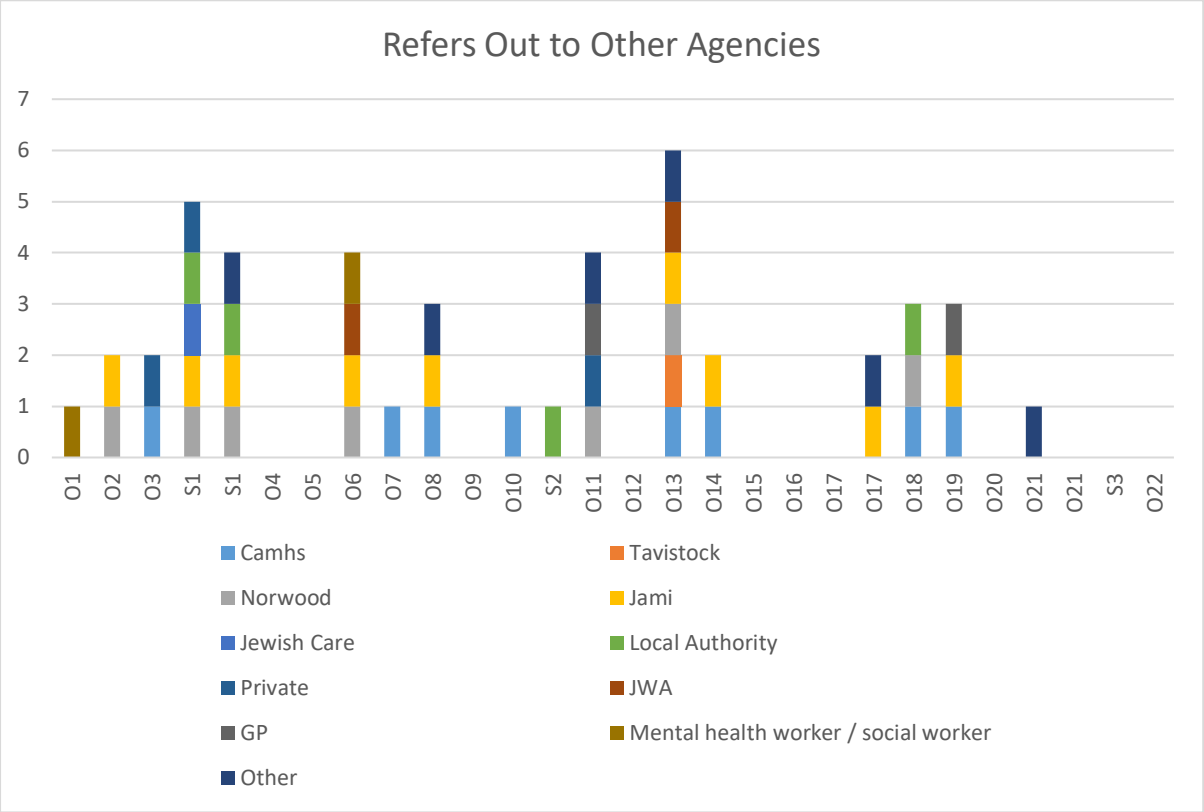


Figure 5 (above) details the named organisations to which referrals are made by numbered organisation (O) and synagogue/overarching denominational body (S).

Several respondents noted that referrals took place on a case by case basis to other Jewish agencies, typically JAMI, Jewish Care or Norwood. Five respondents specifically mentioned referring young people to CAMHS.

- "CAMHS predominantly but with most cases we support GPs to do the referrals to CAMHS rather than us do it directly. Thereafter we will work closely with CAMHS with the referral. In terms of numbers I would say approx. 30 a year (due to very high thresholds and long waiting times). Frequently we may refer to CAMHS who will do a short term intervention and then refer back to us for more work. We also refer to JAMI approximately 20-30 referrals in a year."

Eight out of 11 respondents indicated that they had seen an increase in referrals to their own agencies – largely reflecting the comments above concerning greater awareness of services and enhanced referrals by other agencies, etc.

Most noticeably however, was the overall response pertaining to waiting lists for external specialist support. Of the 17 who answered positively to the question of whether there had been an increase in waiting lists for mental health/well being services following referral out to other organisations, 6 said here has been some increase and 11 a big increase. Typically responses included comments on public sector provision:

- "Young people are having to wait too long for support. Families do not have enough information to know how to support young people who might be struggling"
- "Local authority/CAHMS assessment waiting times seems to have increased not least where specialist intervention/support is required at school"
- "Anecdotally we know that demand and waiting lists for MH/Wellbeing services provided by the VCSE sector has increased significantly over the last three years" [organisation does not provide direct mental health support]
- "Our young people often don't make the CAMHS threshold until things have got too bad"
- "There seems to be a big increase in anxiety related cases and although these children have difficulties they are not then being offered any intervention".

One cross-communal youth network commented on the fact that given that while there are a number of initiatives on offer, there is a need for a strategic response and support for those with low level anxiety who do not meet current thresholds to access NHS/CAMHS support.

On the other hand a number of respondents indicated that there is also an increase in the complexity of referrals they are referring on – in particular in relation to concerns over suicide ideation, self harm, sexual exploitation, gender identity and complex autism.

As above, a number of responses provided to the schools/Universities survey indicated that secondary schools have asked for appropriate programmes on Mental Health Well Being to be developed and made available to them:

- "A number of secondary schools have specifically asked us to develop programmes on Mental Health Wellbeing, as the local provision is over-subscribed, and students with serious issues are not supported". [Non-Jewish agency working with young people around social care issues/learning disabilities]

A considerable number of respondents further indicated that they are aware of increased numbers of applicants for mental health assessments and awaiting appointments, with one respondent noting that in some cases discharge letters stressed the need for continuing on-going treatment which was not available as such

provision was beyond the limited resources available to CAMHS (comment by denominational umbrella group supporting young people and families).

3.3 Future Directions

General comments on future directions/proposals for improvement of services indicate the need for clear mapping of services to determine what provision exists within the community as well as the gaps in service; to provide more detached youth workers as well as informal educators, both in schools and synagogue settings; and the need for greater education of parents on mental health indicators and support.

- "Joined up approaches by leading organisations in the community to ensure the journey of a young person can be supported from childhood to adult life".
- "We need more places where they [young people] can access support. The first time they get support shouldn't be when they try to take their own life. We have seen this 3 times in 2 years"
- "We believe that a close working relationship between the local authority services and the organisations that are trusted and work from within the community is key. Organisations with strong knowledge and experience of the specific community can work to break down cultural negative assumptions about local authority services and ensure that even those from the most insular parts of the community will be able and willing to access and engage with the services available".

Much of the focus on both broader mental health initiatives (for example well-being in schools) and engagement with young people have been on acute interventions, but a number of respondents stressed that there is a relative lack of attention to preventative education regarding mental health and well-being and this does need to be developed further within the community.

- "I am impressed by the Place2Be model, particularly for primary schools. Support parents in establishing boundaries. Equip those agencies who are currently delivering training with adequate tools to offer meaningful support to young people. Understand that Mental Health First Aid is an interesting tool but it has clear limitations and does not equip leaders to support young people's mental health issues. Create a 'one stop shop' where all mental health support initiatives are monitored, assessed and receive feedback in order to ascertain the support our young people receive is of a high standard".

- "More educational training and development of in-school programmes, through agencies such as Streetwise and others".

Amongst the strictly Orthodox, a request was received for members of the diverse groups within it to be employed by local authorities (presumably on the grounds that they are culturally familiar with their community and able to support members most appropriately). Conversely, one agency supporting 'former Charedi' noted that

- "We (XX) would welcome the opportunity to talk with Barnet social services. It is extremely important that they understand the type of support those who seek to make choices outside their ultra-orthodox (Charedi) community or are wavering in their faith are offered. Their community spokespeople will always tell officials to refer such individuals back to Rabbis or others who "understand the sensitivities" of those who have been brought up in the community. It is rare for those happy in the community to seek help from non-community "officials". For those that do, it is a cry for help. Referring back to the community is shutting down that attempt to find a lifeline. Even those who have been living in wider community for years speak of feeling guilty. It is all too easy for communities to lock these vulnerable young people into a life from which they are desperate to escape".

It was also noted by some small agencies that there is also a need for some statutory funding for charities to be supported in doing their job and drawing upon their expertise.

- "Despite all these children having needs, Legadel [organisation supporting young people with learning difficulties who is willing to be identified in this report] does not receive any statutory funding to support these children and therefore we have to do all our own fundraising from within the community. This is obviously an issue as there is a limit to how much an organisation can realistically depend on philanthropy to support needs of children that should be serviced and supported through local authority or government funding. As the extensive report that was recently commissioned by Barnet council and conducted by Middlesex University showed there are many Orthodox Jewish organisations within the community supporting different needs which are all dependent on charity to help keep them afloat and this is no longer sustainable. Legadel should also be viewed as a preventative organisation that is helping ensure that a certain sector of the community does not become a mental health statistic at a later stage!"

Chapter 4 Parents

This section combines parents' responses to the survey questions (45 received) with analysis and findings from in-depth interviews undertaken with seven of these respondents. Parents were selected for interview using a sampling frame which enabled us to include more information from a range of parents who were satisfied with the support they received, neutral (neither happy or unhappy) or dissatisfied with services, as well as including families (as far as possible) with a range of religious observance and denominations (where known) based on their survey responses. The parents who responded (as well as those interviewed) ranged right across the extent of religious practice within the Jewish community. We also include in this chapter some comments made by those organisations interviewed in depth, in relation to their experiences of parenting issues.

Parents' children had experienced serious mental health issues at different ages, ranging from pre-school to well into their teens and during their time at secondary schools. In general parents knew very little about what services existed in the Jewish community when their child first developed mental health and well-being problems.

As our interviews show, several parents did manage eventually to access appropriate services - statutory, community and private – to meet the particular needs of their children, as well as gaining understanding of how to navigate the mental health systems. Whilst recognising that schools had improved their capacity for support in the past few years, they tended, on the whole, to be unaware of what exactly was available in the school. In terms of community organisations, again parents may have known of their existence, but overwhelmingly not the exact services they provided (other than in some cases) until they had undertaken extensive research after their child became unwell.

4.1 Survey Responses from Parents

In the survey responses, parents indicated that they had largely accessed CAMHS (18) and Tavistock (3), school counselling (3) and social services and social work support (3). Health services were the most common route to accessing mental health services, with schools being the main organisation with which they had contact (5).

Table 4 How Services Accessed (survey responses)

How service accessed	%	No. of responses
GP/health services	50	18
Self-referred	19.4	7
Agency/organisation	16.7	6
Relative, friend etc	2.8	1
Other	11.1	4
Total responses		36

Waiting times to access a service varied significantly, from under a month to over 6 months. Even those who managed to access CAMHS relatively quickly, complained of a lack of continuity and that their child was being given support by trainees rather than experienced staff.

Table 5 Waiting times (survey responses)

Waiting time	%	No.
Under one month	35.3	12
2-6 months	29.4	10
1-2 months	17.6	6
More than 6 months	14.7	5
Not sure	2.9	1
Total responses		34

Similarly the level of satisfaction varied substantially, with a large number satisfied or very satisfied with the service. Of the 12 who waited under a month, only one was dissatisfied due to a very poor experience with MIND and one neither satisfied nor dissatisfied. For those who were satisfied or very satisfied, one mentioned the outstanding support they had from their school, and two the excellence of the services obtained from Noa Girls or that they had accessed CAMHS by first ‘going private’ with speeded up the process. Unsurprisingly those who had to wait more than 6 months were very dissatisfied.

Table 6 Level of satisfaction with service (survey responses)

Level of satisfaction	%	No.
Very satisfied	22.9	8
Satisfied	28.6	10
Neither	14.3	5
Dissatisfied	20.0	7
Very dissatisfied	14.3	5
Total responses		35

Key themes emerging from the negative comments were long waiting times, resulting in not being seen until the situation had:

> "escalated into crisis situation' arising from a system that is stretched beyond its capabilities and unless your child has been kicked out of school, is in trouble with the police or loses the plot whilst at CAMHS, they just don't do much";

Other problems children confronted was lack of continuity of personnel, which can be essential for the young person, as well as being given trainees rather than experienced professionals. Other comments pertained to the failure to deliver treatment that took into account the specific needs of the child which several respondents felt (example comments) should be "more centred around what will work for that child".

> "The local authority needs to listen to the needs of the child rather than provide what they have as part of their own suite of services which are not suitable at all".

What also emerged in comments expressed in the survey and in interviews was that CAMHS and schools often did not take parents seriously unless their views were reinforced and backed up by other professionals. Schools were seen as having a problem communicating with parents.

Table 7 Difficulties in Accessing Support for Children and Young People in order of difficulty (survey responses)

Difficulty	%	No
Limited capacity/long waiting lists	27.3	24
Lack of accessible knowledge	20.4	18
Willingness of young person to participate	14.8	13
Stigma with acknowledging issue	12.5	11
High thresholds	9.1	8
Young person/family delayed applying for support	5.9	5
Expense in accessing service	5.9	5
Other	4.6	4
Lack of cultural awareness	0	0
Total reasons		88

In additional comments about accessing services, some survey respondents (and some interviewees) felt that GPs should also receive more education on signs of CYP's mental health. It was felt by some respondents that GPs needed to listen more to parents who were familiar with their own child. At the same time, some GPs were reported as having been extremely helpful and understanding.

Another recommendation from several respondents to the survey was that more access to therapies and greater follow up from CAMHS was required rather than a prescription for medication (and see in Chapter 7, CYP where one interviewee commented on a number of their peers being prescribed medication rather than counselling as a result of long waiting lists). One parent suggested group therapies might be a way of enabling CYP to access services more rapidly.

One survey respondent noted that there is a "Problem [that] CAMHS focus so heavily on a medical model straight away, but one might want advice and support. [A need to] make provision less formal and more appealing".

4.2 Key themes raised by parents

The interviews highlighted that a number of parents only managed to access good quality CAMHS services through first going to private psychologists and therapists to give them a diagnosis. In some instances their children continued seeing private practitioners at some expense to themselves. In other instances, schools only took their children's needs seriously once parents' concerns were confirmed by CAMHs

reports. Yet despite this, one person had spent a considerable sum of money but received a very poor analysis of her child's condition from the psychotherapist which they felt was a rather generic report, however they found the report by the educational psychologist whom they privately accessed useful in leveraging appropriate services. Some parents who had a positive experience, nonetheless, commented that none of the organisations they contacted or worked with had 'joined up thinking', including the need for closer collaboration between children's services and schools. One interviewee could only access support from the school and CAMHs if they agreed to go on a parenting course but these were held during the day which was impossible for parents working full-time requiring a delay of quite some time until they eventually found an evening parenting class which they were on the verge of commencing.

Parents in several cases raised issues of children having to cope with other children confiding in them about attempts to commit suicide[34] and suicidal thoughts, rape and self-harm and where daughters in particular through necessity become 'agony aunts' to their peers. Several interviewees felt schools needed to think about how to develop support and information sharing systems using peer groups, although this would require some appropriate training for young people who were involved.

A parent noted the difficulties in finding alternative schools when their child was either expelled, invited to leave or out of school. For example in one case they were told that a school they had identified stated that they wouldn't take her child because they already had someone with similar difficulties. In addition, in three of the seven interviews, parents reported that their children had spent periods out of school and had been unable to complete their secondary education.

The disruption of changing schools was a problem faced by a number of parents who responded to the survey or who were interviewed. Some young people, both of primary and secondary school age, had gone through periods of a total lack of formal schooling. Two parents who participated had children who were currently out of school whilst others noted that a breakdown in relationships with a school can lead to permanent exclusion.

> "Schools can be quick to accuse parents of bad parenting or problems, without offering support".

Two parents explicitly referred to the requirement or proposal that they attend parenting classes in relation to their child's access to support services. One couple who accessed specialist parenting support classes/sessions through the Tavistock

[34] See also the comment in Chapter 7 – CYP in which a specialist youth worker describes their own child calling them for advice on being confided in by a peer regarding an intent to commit suicide.

where their suicidal daughter with eating issues [although not formally diagnosed as an eating disorder] has been seen on a fairly long basis (after referral from the Barnet Adolescent Service) commented favourably on the support they are receiving from the rolling programme which they attend regularly:

> "So she's seen once a week there, and we're also seen once a fortnight there. The parents [programme] – it's called Parent Works. We've been going there every week or so, now it's every two weeks. ….And now we're seeing the psychotherapist and it's totally different [from previous contact with social workers via the Parent Works service]. Just helping us understand our relationship with [daughter]. Why we react to her in different ways and how to improve on that… the problem with [daughter] is that she doesn't open out and she doesn't tell you anything. So that's useful [in understanding how to react to and understand to behaviours]"

In contrast, another parent who is working on a full time basis expressed a willingness to attend parenting classes but some dismay at the fact that it was a set requirement for her and her husband to access such provision before their children (one child with autism and learning difficulties; and potential mental health issues suffered by the other child who has been reacting badly to the problematic family circumstances) can be seen by CAMHS.

> "And, actually, they've been talking to us a lot, about the fact that we need to do parenting course, and I understand that, I get that we need to provide more structure at home. Both my husband and I work full time, so we don't always have that structure, it's difficult"

An organisation which largely works with strictly Orthodox parents and children, commented in relation to parenting and problems of them accessing courses that:

> "What we're seeing coming up is the kind of, I use this world lightly, but it's a deficit from families of people who've grown up being part of such large families that actually their own parenting is really, the emotional capacity sometimes is quite limited… And capacity in the family, just space and capacity for children to explore, express and raise issues…. We have parents who come and sometimes we feel that the parents need a parenting course rather than the child needs therapy, and we'll recommend that that's what they do. ..But again a very important point [is] that most of our parenting courses are during the day, so if it's working mum, it's hard for her to get in, and there's an additional problem if you've got a single mum, she then hasn't got a babysitter very often that she's comfortable to leave the kids [with], or the babysitter is going to cost

her money which she doesn't have. .. and there's a lot of input [provided] with the family as a whole [even working with an individual child"].

The same organisation commented on the poor communication between schools and homes:

> "often people will come in and say "I've tried the school and the school's not responding." My personal view as well is that children don't do very well in therapy based in schools. I think that it's better to separate the educational place and the therapeutic…We sent one of our therapists into a school and the child was bereaved, and afterwards came into the class absolutely hysterical and the teacher couldn't deal with it, and it was just like he was completely exposed. It just was so badly managed"

Not knowing where to turn was also a common refrain. For most parents, it was a matter of finding out for themselves over time, and trial and error, what worked for their family circumstances or how to access services. One survey participant noted

> "We have been pushed from pillar to post by a range of people, spending huge sums of money for doctors and services that have not helped at all. ..and then nothing… we are just in a waiting game, trying to work out what we can do to give our kids the support they need".

Yet, as one interviewee stated, "so much available support is kept hidden". For example Barnet operates a Special Educational Needs Information Advisory Service which can help parents in moving children to another school, obtain an EHCP and speak with SENCOs. There is also a Barnet Parent Carer Group which includes a working party liaising with CAMHS and another with SENCOs and secondary heads. Finally there is a group ADDISS for ADHD support but these were only found by chance as was the support for siblings (delivered by Norwood). As a parent commented that there exists "a strong support network but it favours those people who are more confident and assertive in accessing it". Such networks also includes a parent support group on Facebook called 'Its Not Just You" which has over 1000 members.

Amongst parents there was little knowledge of Jewish organisations providing support for mental health and learning disabilities. Norwood was mentioned and used by survey respondents and interviewees but even here there seemed to be little

awareness of what exactly they provided. Some had heard of JAMI but not of the kind of services available from them.

Concern was raised by a number of interviewees about services provided for children aged 16 to 18 years and those transitioning to adulthood. Kisharon does provide continuation of support, while another using a private therapist was relieved that unlike the services provide via CAMHS the therapist would continue to treat her teenage child.

What emerged in several of the interviews was the mismatch between schools and well-being of child, for example in relation to a child who could not cope psychologically or socially with a large secondary school. Several interviewees had tried different schools in an attempt to find one that would be able to deal with their child and provide the right environment for them to manage. A number of parents reported that they had had to negotiate transfers between schools and finding new schools following expulsions because the school thought it couldn't cope with the child's illness, or behaviour, or the child was not an academic high achiever (see further the Education chapters where this is also a prominent theme in relation to academic pressures and children entering sixth forms).

> "Jewish schools are not holistic and only care about exam results…they need to create a holistic 6th form for young people who have not done well in their GCSEs".

Parents repeatedly commented on the fact that they felt that schools should do more to educate children about mental health and well-being issues. One parent suggested the need for "Having the [mental health] service operate within schools so that it normalises it and removes any stigma. Giving young people the tools to deal with emotions and mental health" Whilst another stated that

> "The Jewish community needs to do more to educate young people about mental well being, rights of the child and how to use digital media in a sensible way. There must be more support and discussion in schools for young people on mental health issues".

As noted elsewhere in this report, it was felt that greater awareness of conditions, triggers and warning signs of ill-health, would serve to break the stigma associated with mental health. In contrast, some parents praised their childrens' schools, (both primary and secondary), and stated that they found the support they received was outstanding.

Overall there was a clear sense that greater levels of training and awareness raising within the education system would also help identification of warning signals and appropriate responses rather than (as a number of parents commented) schools refusing to accept that any problem exists, or even giving a wrong diagnosis (such as 'attention seeking') which can seriously set back children. The lack of early intervention in dealing with ADHD and/or inappropriate ways of dealing with challenging behaviour in schools could subsequently lead to severe mental health problems, such as self harm and suicidal ideation as several parents recounted.

A buddy system, such as the one facilitated be Noa Girls (which was praised by a number of respondents across the entire project), was seen as potentially a help for young people with mental health issues, enabling them to feel included rather than excluded. It was also noted that CYP also want to talk to other young people rather than older adults who might be seen as out of touch or closer to established systems within the Jewish community. Some parents suggested that it would be important to form 6th form discussion groups which engaged with issues around mental health, and this could lead to the provision of training for young people (for example in relation to mental health first aid).

A very thoughtful response on gender differences in presentation of some mental health and associated conditions was provided by one parent:

> "I think there's definitely a distinction in autism in girls, because I think people's understanding of autism is autism in the convention sense, and then ADHD as well. You're thinking about boys who are not speaking, who are bouncing off the walls, who are being disruptive and violent, that's what people think when they think of ADHD and autism. But, in girls, it's completely different, in girls they often are quiet, unassuming, certainly not violent or aggressive, apart from their meltdowns, which they usually have at home that the wider world doesn't see, anyway, and struggle socially and with communications, but in a much subtler way. So…boys on the spectrum get diagnosed earlier, and probably get the help that they need. But, girls, certainly don't, and that's when it develops more into mental health problems…girls with high functioning autism, Asperger's, however you want to call it, are often diagnosed late, because people don't see all the symptoms".

As one parent summarised the situation prevailing for young people now – when compared to an earlier period:

"I think the pressures now are so beyond what they were then [when she was at school], academic pressures to get into the right schools, and the right universities, get the right grades. The social pressures are off the chart, and yes, you know, obviously, you can point to social media, and that is a part of it, but I don't think it's everything. I actually also think that the pressures on teachers and services, are such that they are not enabled to provide the level of service that they want to, and I think that that's part of the problem.

You know, the squeeze on resources within education, and within the NHS, means that support is not there, and when it is there, it's lacking, and it takes forever, by which time things have got acute".

Recommendations

The recommendations parents gave were overwhelmingly related to the difficulties outlined above in accessing support. In particular many mentioned what schools could do to assist CYP and their families.

- To give schools the tools (education) to deal with mental health issues and enable them to be more proactive in identifying and supporting CYP.
- To educate parents, teachers and young people on mental health
- To give young people the education on, and techniques to deal with, mental health issues as well as providing more fora for discussion on mental health and well-being.
- GPs should receive more training on recognising and treating/referring on CYP with mental health difficulties.
- For a whole system approach to delivery of provision for children aged 16 to 18 years with mental health problems, who are out of school and those who are transitioning to adulthood and facing disruption of support services or delays in accessing adult services which might not be fully appropriate for them.
- That schools need to cater for the diversity of pupils and not just the academic high achievers as less academically able children or those who are struggling can experience significant wellbeing difficulties as a result of a strong focus on exam results and transitioning to university
- Parenting and other courses need to be arranged and delivered so as to take into account parents' ability to attend (for example working parents or lone parents with other children who require care).

Chapter 5 - Education Sector: findings from the survey (schools and university JSocs/Chaplaincies)

In total the survey yielded 24 (useable as in completed in any meaningful manner) responses of which 17 were schools from across the denominational spectrum. Of these, 6 were secondary schools; 11 were primary and one a 'special education' school which has pupils across the age-range. This latter school has been convenience coded as secondary as the vast majority of pupils are of secondary age although a small number of places are provided for primary and junior school age children).

The remaining seven respondents were based in universities (Chaplaincies/JScos in 6 cases) or in one case was responsible for provision of over-arching support role for Jewish services within the university sector.

In reviewing the data provided below it is important to note that not all educational establishments answered all questions, although the 24 responses included in this analysis had completed at minimum a substantial proportion (60%+) of questions in the survey or had indicated throughout where a question was not applicable.

Table 8 Predominant geographical intake of Educational Establishment[35]

	Barnet	London-wide	Other*
Schools/universities	7 (35%)	2 (10%)	11 (55%)

Whilst universities with a Jewish presence substantial enough to offer a JSoc or access to a university chaplain inevitably responded that they had student members or were available to students from across the UK (or in some cases further afield), schools by definition had a smaller catchment area and constituent pupil body. This held true both for independent and state-maintained schools.

- Overall schools located in LB Barnet reported that pupils were in 70-85% of cases resident in the Borough. Of those schools who were either leading Jewish Secondary schools or who accepted students from a wider area than the Borough in which they were located, in each case approximately 70% of pupils were Barnet residents (range from 50-85% of pupils resident within Barnet). No university chaplaincies/JSoc respondents provided this granular level of information and it is likely that such data is not held at a local level.
- The 'other' category in the table above consists of four schools which include service users from Barnet and some other Boroughs within and beyond London. For the seven university based respondents, all but one was located

[35] Numbers given in this table are less than the number of survey responses treated to full analysis as a small number of respondents omitted this information but then completed the remainder of the questionnaire adequately enough to enable meaningful analysis and inclusion in the sample.

within ‘Jewniversities’ or institutions with a large Jewish student intake and well-established reputation amongst Jewish young people and their families.

Although the link to the survey and an invitation to participate were sent to eight ‘non-Jewish’ schools (selective and typically - but not always - independent) based in London who are known to hold Jewish assemblies (used as a proxy for evidence of a relatively substantial Jewish pupil number on the roll), none of this group of schools responded to the survey despite a ‘chase-up’ email being sent.

Of the seventeen Jewish schools who responded, 5 indicated that they were affiliated to NAJOS[36] (with two of these five also having associations with PAJES) and 12 were members of PAJES alone[37]. One strictly Orthodox school – member of NAJOS – stated that in addition to membership of NAJOS they had:

- “Informal but established collaborative link with 3 similar schools; Brent Schools Partnership and the Brent Teaching Schools Alliance”

Of the 24 educational sector respondents; 5/7 Chaplaincies/JSocs indicated that services delivered/membership was not exclusively for Jewish students, whilst 3/17 schools indicated that they had non-Jewish pupils attending their educational establishment.

Perhaps unsurprisingly, of these three schools with non-Jewish pupils, two were affiliated to PAJES rather than NAJOS and one did not indicate that they were members of any umbrella organisation or schools network.

It has been posited during our analysis that some of the schools stating that they had non-Jewish pupils may be interpreting this not simply to record that children of other faith backgrounds or ethnicities were pupils, but also to indicate that children who had been raised in a ‘mixed household’ and who were not Jewish in the halachic sense (or as determined by particular rabbinic authorities even if accepted as such by other denominations) were attending a Jewish school[38].

Overall, across all sectors (JSoc/Chaplaincies/Schools) where information was provided, indications were given that approximately 95% of pupils/students and service users/members were Jewish. Interestingly (leading one to many fascinating avenues of conjecture) one JSoc reported that only 70% of members were Jewish.

Only seven respondents (1 school/6 JSocs/Chaplaincies) provided precise information on age-band of students/members. The school which gave the most detailed

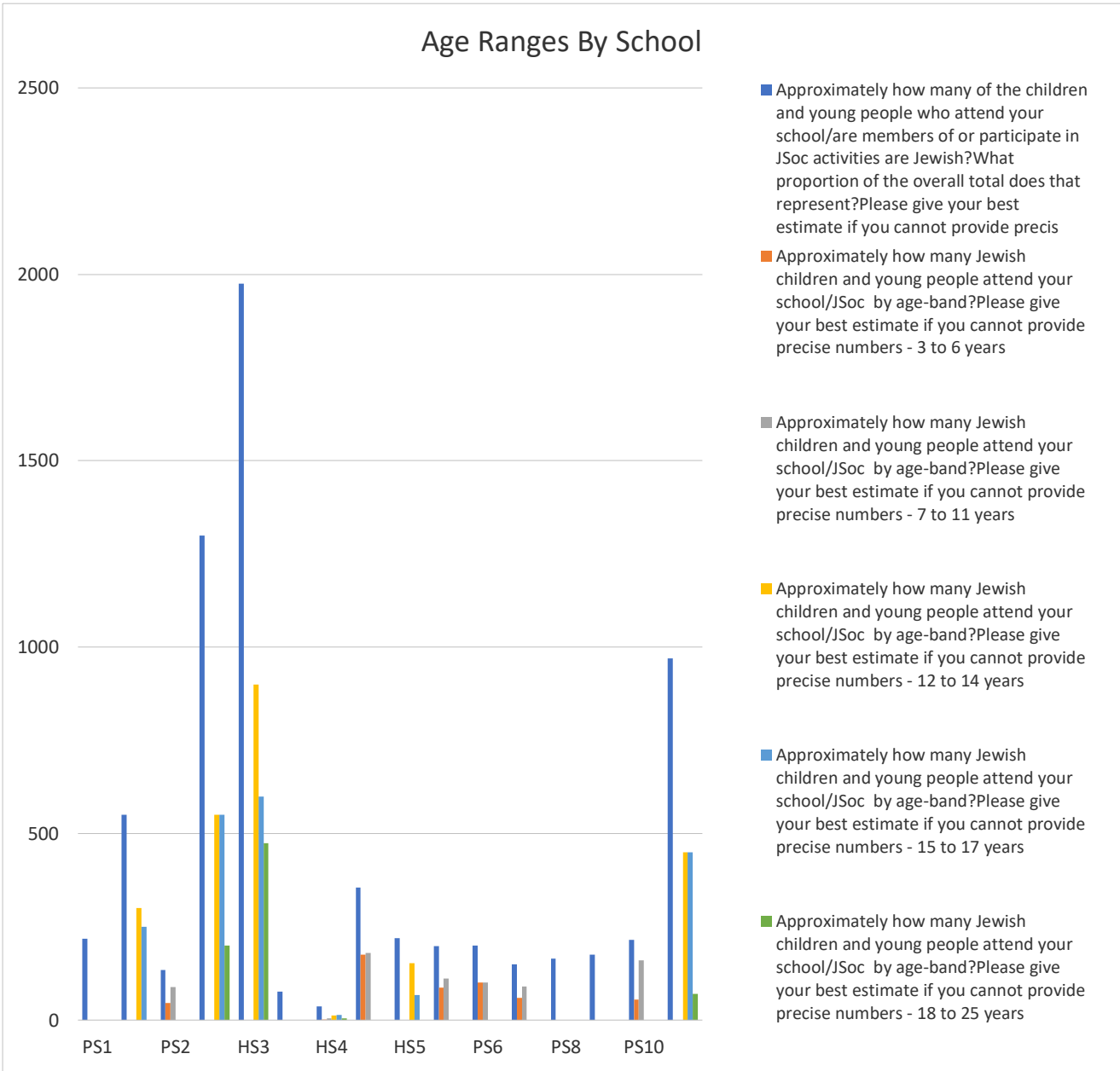
[36] Which is no longer functioning as a Schools network since the Spring of 2018 although respondents to the survey had replied before NAJOS ceased to be active.
[37] One further school had evidently commenced but failed to complete the survey - providing this information and their name but failed to supply enough further information to be meaningfully included in the sample.
[38] For example, the situation which the ‘JFS case’ R (E) v Governing Body of JFS [2009] UKSC 15 was considered.

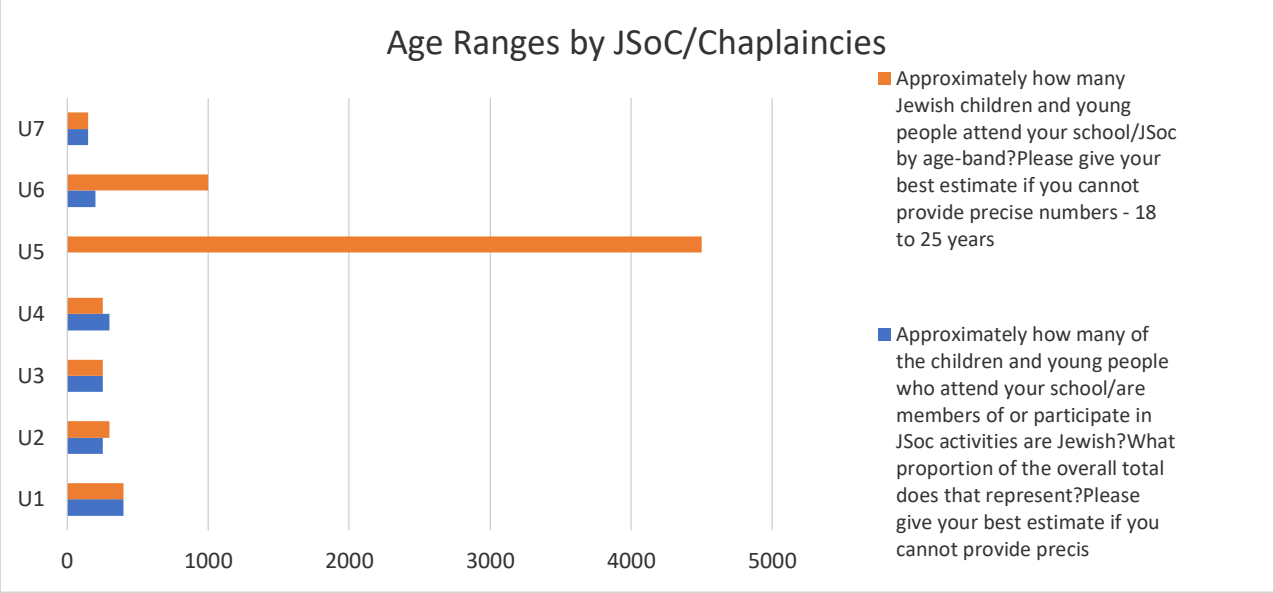
information by age-band had 199 Jewish pupils below the age of 11 and by deduction, based on provided data, approximately 5% of the school roll are non-Jewish.

Although the majority of schools who responded did not provide information on the size of the school roll, a review of the websites of schools who participated has enabled us to complete a number of gaps in data returned; illustrated in Charts 5 and 6 below. It has not been possible to complete such an exercise for University Chaplaincies/JSocs where this information was not provided by respondents.

The centralised Jewish education/support organisation response indicated around 4500 members spread through the whole of the UK, while more localised responses (JSoc/Chaplaincies) indicated a mean of 360 members with a range from 250-1000 members aged between 18-25 years.

Figures 5 and 6 – Age Ranges by school and JSoc/Chaplaincy





PS = Primary School, HS = Secondary School, U = JSoc

Of the twenty respondents who replied to the question on whether procedures existed if concerns existed about a young person, 4 Chaplaincies/JSocs and 16 schools, indicated that formal and established procedures exist in relation to providing access to services available to children and young people in need of support.

Despite one secondary school stating that there were no established procedures or protocols for referrals to services, they indicated that referrals out (e.g. to CAMHS) and also access to internally delivered support services exist, occurring following discussions between the pastoral services support staff, class teachers and the Head Teacher.

Internal evidence within this responses flag up a process of case by case decision making in which this relatively small school proceeds through a fairly informal holistic process where teachers concerned about a child then refer to the pastoral support staff and either they, (following group discussion) or the Rabbi agree, (depending on level of concern) about whether internal support mechanisms should be operationalised or a referral out made as required – for example to agencies such as Noa Girls, CAMHS, Jami, Norwood etc.

Of the three JSocs/Chaplaincies who responded that **no** established procedures existed to ensure referral to internal or external services, all respondents indicated that they would take a case-by-case decision on whether to contact the university counselling service or recommend that the young person approached MIND in their local area or a GP. One very large university although having access to internally provided well-being services does not appear to have established protocols for support/referral to access services and the respondent was also unable to advise what action they personally would take in relation to supporting a young person to access external services.

Of the remaining respondents who had established procedures and protocols pertaining to support/access ten schools and two chaplaincies (including the central agency/UJS) provided more details e.g.:

- “My chaplains all have a protocol to follow. They are attached to Universities around the UK and are aware and make use of the referral procedure available to them”.
- “I discuss with the student the matter and then help them move on to get help from the appropriate organisation”.
- “Informal referrals to in-school provision can be made by form tutors, Year Heads or other pastoral staff; Referrals to more specialist services are done by senior staff liaising with external agencies”.

As is more age-appropriate, young adults in universities (18-25) were supported to take steps to access support independently, although two chaplains indicated that they would take advice from colleagues within university counselling services if they were worried about a student.

In school contexts there were typically formal expectations about referral routes and in-house discussions took place alongside safeguarding procedures as necessary. Typical responses in relation to such referrals (either for internal or external services) were as follows:

- “As a special school we are constantly aware of pupils potentially having additional mental health concerns. Staff are alert to this and will report to the head teacher any concerns”.
- “Safeguarding team - DSL (Head teacher), Deputy Head, SENCO, Head of KS1. Staff follow safeguarding policy SEN concerns (including emotional health and wellbeing) are referred to SENCO and discussed in Senior Team Meetings Parenting concerns - we ask parents to self-refer to Norwood / offer parenting support groups”
- “The class teacher will discuss with me as lead on pastoral. We approach parents and meet with the, We try ‘in-school’ strategies initially before recommending them to seek support from GP to get access to CAMHS or seek a private referral. We have a direct link with the Priory. Our school counsellors see prep pupils from Yr 4”
- “The School has established referral processes and has close links with relevant social services. There is a dedicated DSL, deputy DSL and fully trained Safeguarding Team”.

Table 9 Summary of referral routes/procedures to enable access to services

	Yes	Schools	JSoc/Chaplain	No	Schools	JSoc/Chaplain	Total
Established procedures for providing access to services/referrals?	16	12	4	5	1 1n/r	3	21
In-house opportunities/facilities?	16	11	5	4	1 1 n/r	2	20
If services are not available, do you have procedures for external referral?	15	12	3	3	1 1 n/r	2 1 n/a as central chaplaincy	18
Do you refer out to other agencies?	16	13	3	3	1	2	19

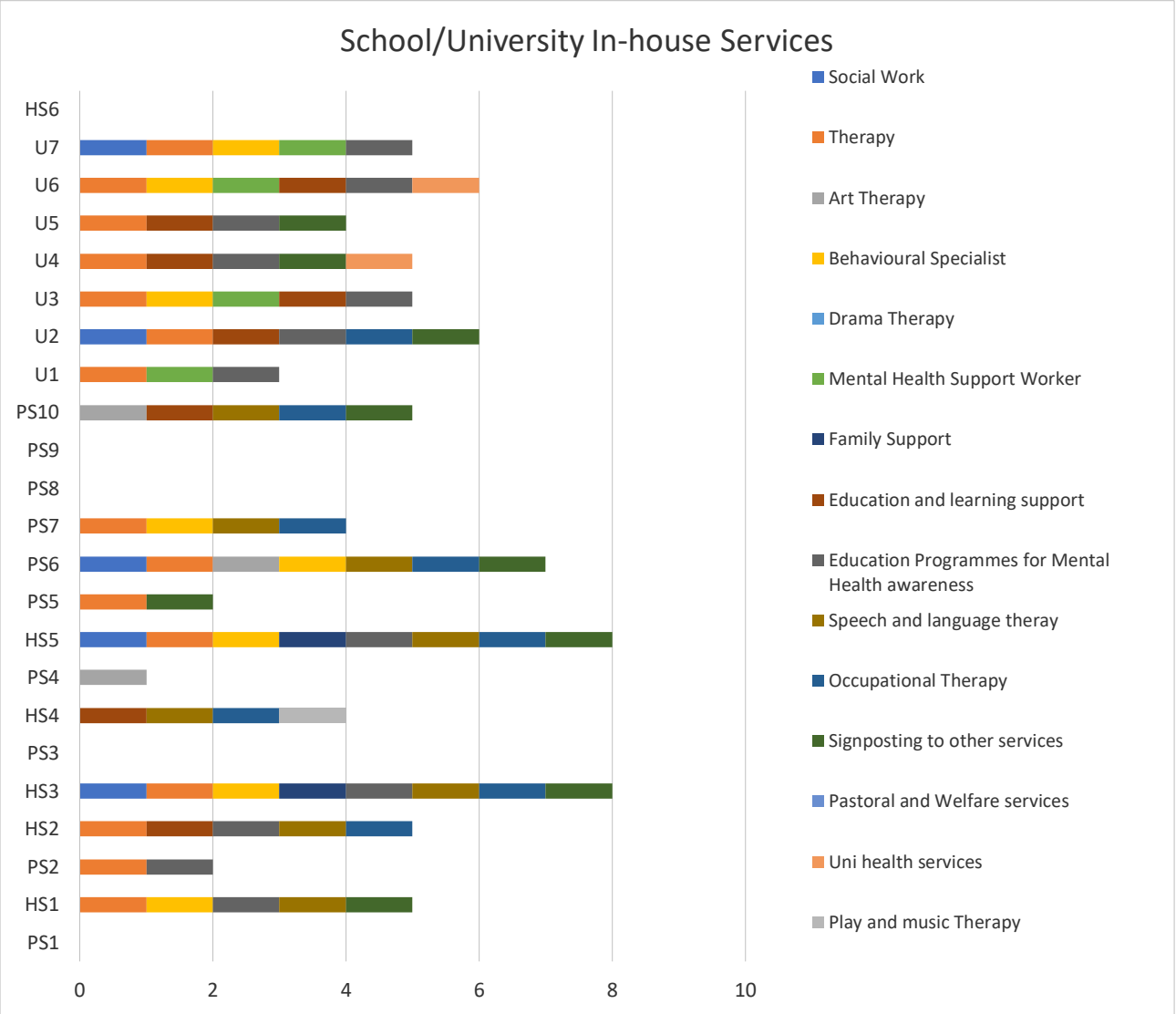
Typical comments in relation to internal service facilities (12 responses received including two from Chaplains/JSoc) include:

- "Students (and/or parents) can self-refer or we can refer them to school counsellor. We have recently expanded our provision. We also have a universal service (voluntary, run with JAMI) on education for well-being e.g. how to manage stress, how to build resilience"
- "School counsellors have times set aside to see prep pupils as well as in senior school. There are two counsellors, both in school for one day a week. We are also running whole school mental-health programmes: the 10 keys to happier living".
- "[Internal support available via] Class Teachers, Senior Leader. There is no counsellor"
- "School based psychotherapist (1 day a week) working with 14 children over a 2 week cycle. SENCO manages referrals from class teachers"
- "We do not currently have a school counsellor (though someone is training as an unqualified counsellor for preventative services not requiring professional intervention). We can refer to contracted-in services by an art therapy provider delivered on school premises".
- "I would contact the university chaplaincy or student services" [JSoc response]

Table 10 Services provided in-house

Services Available	No	Schools	University based
Therapy/counselling	15	12	3
Education mental health awareness	12	10	2
Behavioural specialist/support	8	7	1
Education and learning support	8	6	2
Signposting	9	7	2
Occupational therapy	8	8	-
Speech and language therapy	8	8	-
Social work	6	6	-
Mental health support worker	6	3	3
Family support	3	3	-
Art therapy	3	3	-

Figure 7 – School/University In-house Services



PS = Primary School, HS = Secondary School, U = JSoc/Chaplaincy

Other comments (University based respondents)

- "We have recently collaborated with a Jewish counsellor to be giving emergency counselling for students in need, as waiting for counselling in all other facilities in university or NHS can take a few months". [University Chaplaincy]
- "All our University chaplains have training in mental health first aid and are equipped to help students through certain things like bereavements and anxiety surrounding exams and or family/friendship disputes. More serious mental health problems need to be referred to other services. [UJS]"
- "We have a Chaplain who helps with finding the right service for each case within the university" [JSoc]

Universities have in addition to the above, access to institutionally provided health service provision e.g. nurses, GPs, counsellors

Eleven schools provided additional comments e.g.

- "School is working towards attaining the Optimus Wellbeing at Schools Award Have a mental health lead in the wellbeing coach and head of pastoral"
- "Our autism provision provides OT, SALT and Social/Emotional support and learning for to those on their roll. Other students are provided with these services if specified on EHCPs but less likely to be in house. Several staff are trained in mental health awareness but designated leadership is included within the role of Deputy Head (pastoral). See earlier answer re well-being support provided by JAMI".
- "We have an established a 'Health Hut' provision through which students can receive onsite support through external experts".
- "SENCO responsible for emotional and mental health of the children Psychotherapist - school and parents part fund"
- "We have two members of staff currently on training to be mental health champion leads"

In addition, one school referred to provision of play and music therapy in addition to the services outlined above under the broad categories of in-house provision.

Table 11 Agencies to whom referred out:

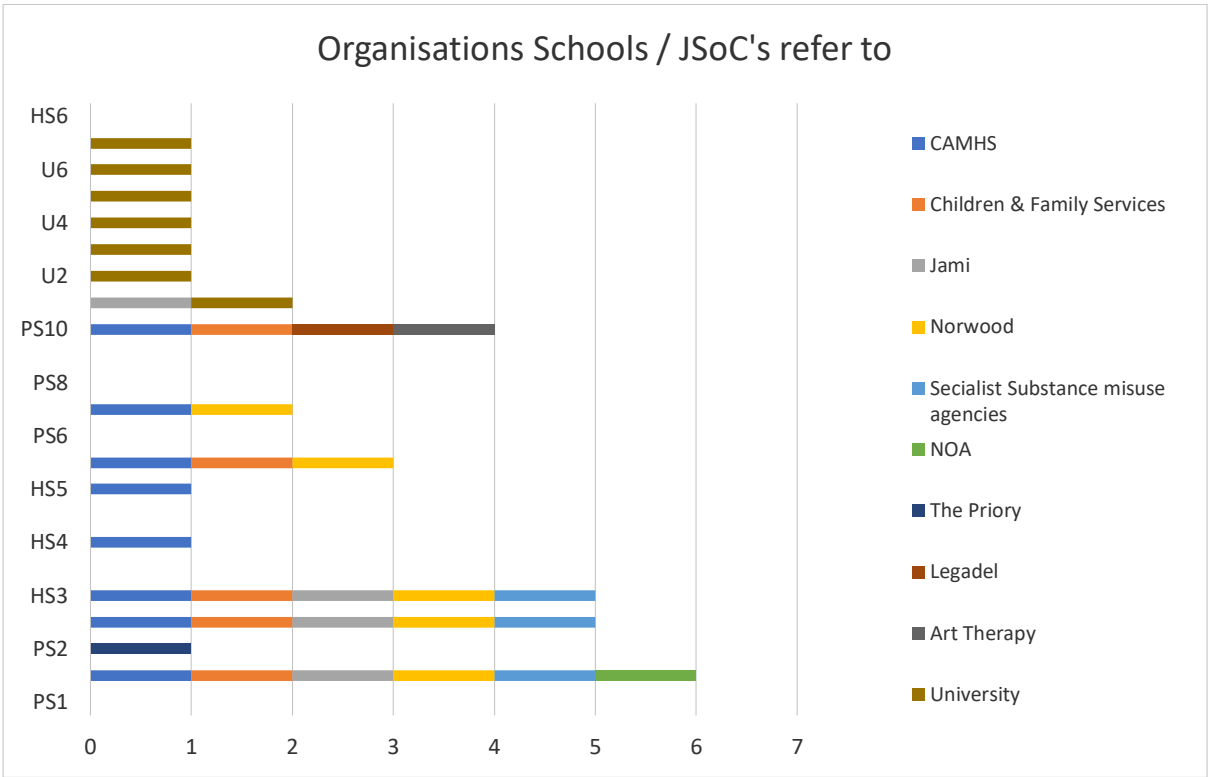
Agencies	**No**	**By Schools**	**By JSoc/Chaplains**
CAMHS	8	8	-
Children and Family Services	5	5	-
JAMI	4	4	-
Norwood	6	6	-
Specialist substance misuse	4	4	-
Other*	9	3	6

*University services (chaplains/JSoc); Priory (private school unable to refer direct to CAMHS); GPs as route into CAMHS (private fee paying school); Art therapy for children; Legadel (learning support); Noa Girls (holistic services for Orthodox girls);

“Depends on circumstances [which agency referred out to]”

“suggest parents seek referrals from GP”

Figure 8 – Agencies to whom referred out



PS = Primary School, HS = Secondary School, U = JSoc

5.1 Waiting lists for in-house services [responses from schools/JSocs/Chaplains]

18 respondents replied to the question on waiting lists split evenly 50/50 between those indicating that there were waiting lists for services and those who said that there were not. Responses which indicated that **waiting lists existed** consisted of returns from 5 schools and 4 university chaplains/JSocs:

Amongst JSoc/Chaplaincies/UJS respondents three quarters [3 out of 4 respondents] indicated waiting lists existed which is of particular concern given stresses on young people associated with exam pressures and a clearly identified increase in suicide and mental health matters across the entire higher education sector (see further the literature and policy review in Chapter 1). The fourth respondent in this category indicated that as their senior role was within a country wide service supporting young Jewish people in universities it is was not possible to respond fully although they were aware of waiting lists for counselling and support across the entire university sector. Comments from UJS/chaplains were as follows:

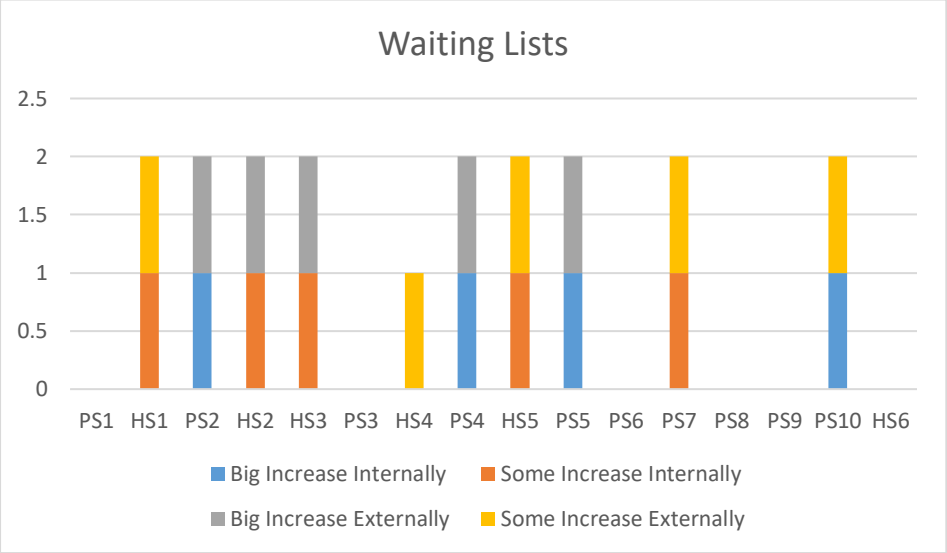
- “For counselling and therapy, waiting lists can be for a few months.
- There are often specific number of sessions available for therapy and there is triage for mental health issues. High priority cases are seen quickly or referred to NHS services very quickly”.
- Students services in general at uni have a long waiting list of a few weeks”

Amongst schools – where respondents referred to waiting lists for in-house services the following replies were recorded:

- “short waiting list because the counsellor is new and monitoring how many sessions per student”
- “We have increased our Counsellor hours in order to manage the demand. The waiting list is not huge and can be managed by limiting the number of sessions per student - but we could always use more hours if we could afford them”.
- “There has been an increase in the need for support for exam stress, anxiety, family relationships, self-harm and bereavement”.
- “We have a waiting list for the school psychotherapist - this list varies depending upon need”
- “Art therapy, Speech & Language therapy and Occupational therapy all have waiting lists of approximately 6 months”.

Of those nine respondents who indicated that no waiting lists existed for in-house services 3 were chaplaincies/UJS and six were schools

Figure 9 - Changes in waiting lists for services/referrals (in-house/external)



PS = Primary School, HS = Secondary School – gaps indicate no response to question

In total 10 respondents replied to the question on whether they had seen any change in referral rates/waiting lists both in-house and to external agencies.

No respondents stated that there had been no or a limited increase in demand.

Three schools and the UJS indicated that there had been a big increase in waiting lists/demands for in-house services whilst seven respondents (one chaplaincy and six schools) reported 'some increase' in in-house service demand.

Similarly, 10 responses were received in relation to waiting lists for external services. Six respondents (one JSoc, and 5 schools) indicated that there had been a 'big increase' in relation to external services with five (all schools) indicating 'some' increase in referrals out.

Explanations for increased rates of referrals out were provided by only two respondents (both schools) One stressed that they have responded by increasing their internal provision and setting up a dedicated 'health hut' and accessing increased funding for mental health support without providing an explanation for increased service demand whilst the other respondent suggested:

- "The increase is possibly due to increased awareness, new leadership on Inclusion resulting in different strategic approach, increased recognition of the need for fully professional interventions in some cases, and increased availability of appropriate service providers that we can bring in-house (e.g. Art Therapy for Children, Legadel)".

Comments by education sector respondents on identified areas of particular need/concern impacting young people from within the community are collated below

When asked for additional recommendations which would assist in supporting CYP in need of mental health support Schools/Education providers made the following statements which to some extent mirrored those of parents and young people identified within other elements of the survey and within the focus group and interviews:

- "Make services more accessible and affordable, skype counselling sessions etc."
- "Greater onsite provision. Support need for parents and staff".
- "More awareness + clear guidelines [on access/conditions]"
- "Greater awareness, discussion and education for students, parents and organisations".
- "Make them [pupils/students/parents] aware of providers and train clergy to be Moreno[39] effective first responders"

[39] Jacob Moreno was a pioneer in the immediate post World War Two context in relation to group psychodrama therapeutic approaches to supporting returning (traumatised) military personnel. Interestingly this respondent's the use of a specific, identified methodology highlights to some extent the variability in approaches utilised by schools, universities and practitioners with no single cohesive model or approach found across the education sector. It is recommended that a more cohesive

- "Poor resourcing means thresholds are very high for admissions. Some students have been very badly served by the lack of mental health beds in urgent and distressing situations. The transfer from CAMHS to adult mental health services at 18 is not well managed and doesn't reflect the reality of school students" [University respondent].
- "More parental education to help remove stigma. More services within school – but also need the funding for this. Training for all staff with regular updates"
- "Better signposting to [within] schools - what is available and for whom"
- "£££: Establish culturally-appropriate providers"
- "Reducing waiting lists. More in-house services - easier to access [external] services"
- "Acknowledging that pupils with SEN may also need support for mental health needs"
    - Schools: A need to engage with and change parents' attitudes to mental health.

5.2 Additional Questions posed to Schools

Following on from analysis of the education survey it was identified in discussion with the advisory panel that it would be helpful to have a clearer understanding of both the precise form of training/qualifications held by in-house schools counsellors or leads on mental health/wellbeing, as well as greater awareness of what forms of training schools based staff felt would be helpful in enabling them to fulfil their role.

An additional four questions were sent out to all schools who had participated in the survey – as well as an invitation to participate in a focus group (see further below). Only two responses were received from recipients of the follow-up questions; and of these only one was able to confirm attendance at the focus group.

The additional questions asked were as follows:

1) Please can you provide addition information in relation to the types of therapy/counselling which are available or provided within the school (where relevant) e.g. psycho-dynamic; Cognitive Behaviour Therapy (CBT); play therapy etc.

2) Please can you advise on the type of qualifications or training possessed by the staff member or person offering counselling/support – e.g. qualified counsellor; educational psychologist etc.

approach to delivery of therapeutic support and preferred models might prove effective in supporting CYP who have move schools (perhaps following on exclusion or if they have not settled at a particular school) enabling at least some continuity of care in an educational setting as well as shared knowledge sets and standards of provision.

3) What type of training is currently provided to teachers/staff in relation to mental health awareness and supporting children and young people (CYP) experiencing stress or mental health issues.

4) What type of training would be most helpful to you in terms of equipping your staff with additional skills (where needed) in relation to supporting CYP mental health and wellbeing within your school.

As above only two responses were received both from secondary schools (coded to match the key provided for individual educational establishments included in the charts above). The limited additional response makes it difficult to draw firm conclusions overall – other than to enable us to note that a small number of academic establishments are offering a high level of holistic service provision, indicative of a clear leadership approach to engaging with mental health issues for CYP. In contrast, some schools who are working to support students experiencing particular needs have staff members with specialist training sets, but there is a lack of resources to support an overall whole school approach, leading to a need to seek advice and information externally on an ad hoc basis.

School HS1 [High School 1] noted in their supplementary response: [response numbers refer to the question numbers above]

1. The trained school counsellor uses an integrative therapeutic model; the wellbeing practitioner uses coaching mentoring including the use of growth mind-set and the PERMA mind-set; mindfulness, positive psychology, peer mentoring; strengths approach to study; art and wellbeing, art therapy; Heads Up from Norwood. [Some] students have cognitive skills lessons in year 9

2. Counsellor has post graduate diploma BACP approved in counselling children in schools, foundation course in counselling skills for working with children accredited by Place2be/UEL and a broad range of CPD covering the following topics – grief and bereavement, autism, psychology of suicide, domestic violence, music therapy, group work, art therapy, therapeutic game play, self-harm and eating disorders, intro to CBT therapy, mindfulness, mental illness in boys and young men ; wellbeing practitioner has accreditation in professional coaching, trained to teach positive psychology, certificate in teaching happiness from ICEP. She also has experience in working in a Jewish youth movement, is a trained facilitator with Young Happy minds

3. Various staff have undertaken training with MHFA UK; Place2be, some bespoke for school training from CAMHs therapists – whole school mental health awareness and training inset covering anxiety and depression, self-harm, eating disorders and developing your own mindfulness; some trained in ChildLine peer mentoring; autism training, sessions on attachment therapy; year 7 tutors trained to deliver Norwood Heads up

4. Practical techniques for managing students with borderline personality disorders, identifying and differentiating between ‘real’ and ‘fad’ self-harm

presentation, effective calming techniques, coping strategies for their own time management and work life balance

Whilst **School HS4** stated that:

1. Music therapy for all students, Play Therapy when needed for specific pupil for example LAC. Both have recognised qualifications. i.e. Nordoff Robbins.

2. N/A

3. Unfortunately none. Advice on case by case provided by CAMHS.

4. General awareness of the high incidence amongst young people with learning difficulties. Managing behaviour which is a result of mental health issues. Working with parents of these students.

Following on from analysis of the survey and after discussions with the advisory group, two schools were selected for indicative interview to highlight best-practice and core challenges faced by schools (one mixed primary central Orthodox affiliation and one single gender Orthodox secondary school). In each case the Head teacher was interviewed and in the case of the primary school – the SENCO participated in some of the discussion. The findings from these two interviews, a mini-discussion group with SENCOs and a focus group with core education professionals leading on mental health and wellbeing are presented in the next chapter.

Chapter 6 - Education Sector: Interviews with head-teachers; discussion session with SENCOs and focus group with school specialist professionals

6.1 Interviews

As these interviews took place with Head teachers, inevitably the approach was slightly different from that articulated by SENCOs and other education-based respondents who did not have to take responsibility for overall policy direction, prioritisation and budgeting within a school. Given the differences in age groups of children and the size of the two schools (a large secondary school and a medium sized primary school) it was noticeable that both interviewees [responses coded as PS/primary school and HS/high school] were similar in their approach. Both Head teachers sought to instil a set of core values and embedded mental health engagement/awareness throughout their schools by the process of open discussion of issues, targeted events, and retaining a clear oversight of structures and the changing terrain (both external and internal) which might impact delivery of wellbeing for pupils. Evidence existed in both cases of close and regular contact between the Head teacher and pastoral/SENCO colleagues.

Perhaps the most striking similarity in findings between both schools selected for interview consisted of the quality of leadership evidenced by both interviewees, as well as the adoption of a whole school approach to well-being and mental health; and a focus on prioritising resources towards this element of educational support.

PS: "So, we run a PSHE curriculum, and we follow the xx [local authority] Curriculum, that we start from reception through to Year Six, and within it there are units of work on mental health, resilience, self-esteem, confidence, bullying, body image, you name it, everything that falls under the mental health remit, there is a taught unit. We also have our [tailored in-school] Curriculum designed by the entire [school] community, three years ago, and it's based on the question, if a .. child aged 11, is the fully well-rounded child what would we all want them to be, excluding results, what would be our outcomes. … so, we have three strands, we have 'myself', 'my relationships', and 'my learning'. There are three overarching principles, and these are fundamental, a Jewish identity.. running alongside that, this 'myself' curriculum is fundamental to our mental health and wellbeing programme".

HS: "I think at some level, everyone in the school… it's everybody's responsibility. For some people it's more responsibility than others. So, for example, where staff are able to recognise and understand the traits of autism, recognise changes in behaviour, recognise that a kid might be developing an eating [disorder] – what are the signs? … if you're the science teacher and you see the kid six times a week, maybe you see something that head of year doesn't necessarily see. It's about ..in the same way that everybody has taken responsibility for safeguarding, this needs to be something as well. I would go as far as saying that I would think that down the line, all teacher training courses across the country – there should be modules in this now. And then we've done lots of CPD for staff on mental health and wellbeing, also focusing on their

own [wellbeing], because you can't expect staff to teach or help students with their own wellbeing if they're not that way themselves"

PS: ""One of the services we've used and implemented here, has been Norwood Heads Up Education Programme, so we did that two years ago, with one-year group, who were particularly immature, and had lots of internal wranglings between them. So, we did a training course for two of our teachers, and then they implemented that within the school, and it was very successful… I also send children on the Stepping Up Course at Norwood, which is for their self-esteem"

6.2 Head teachers Summary of Key Concerns impacting CYP's wellbeing

When asked to prioritise or highlight issues which they saw as impacting on the mental health of their pupils there were understandable variables in response, given the diverse age ranges involved.

However, both interviewees flagged up concerns over **social media use** and awareness of how this could impact children and young people as well as **parenting issues** and the high level of **stigma** pertaining to mental health within the community (see further below).

6.3 Processes followed when concerns are raised about a CYP's wellbeing

Whilst it is clear that it is not always possible to simply directly transfer over models used in smaller education establishments such as primary schools to large secondary schools, there is scope to adopt certain practices across the sector - such as regular team meetings to discuss how to support a child who is causing concern (where these collective discussions do not already exist). Such meetings (as highlighted in the quote above from HS) enable a 360 scoping exercise to be taken in relation to a child given that different teachers and support staff will have different levels of contact with an individual pupil. (See further the theme of a need for better in-house communication raised within the focus group).

In the Primary School interview the Head stressed how:

> "there are team meetings held fortnightly during which 'pastoral conversations' [take place].. every teacher who teaches a child in a certain year group, has a pastoral conversation. This is really, really key to us meeting the needs of children's mental health.
>
> So, for example, if a child in Year Four's parents have separated, and that child is presenting with difficulties, all the secular teachers, the Jewish studies teachers, the music teacher, anyone else who teaches them, will join that meeting for the first 15 minutes of the afternoon, and they will share concerns, queries, and come up with a plan for support. If it's low level, that will be kept

within the year group. If there are issue that are broader, then that will be referred, either to my Senco, or to the pastoral lead for their phase. The pastoral leads for each phase sit on the leadership team, and everything that's discussed at those fortnightly meetings, or raised as issues, comes back to the leadership team for a discussion once a week. So, every Tuesday we meet, and we discuss every child causing concern, and agree whether or not we need to make referrals, whether or not the interventions we've got in place for them are working, or whether we need to do something different"

In the context of the large secondary school, access to counselling or therapy is accessed by pupil via self-referral or following referral by Year Leaders and/or triaged by the Head of Pastoral Care if it is considered that it would be problematic to wait for a longer period of time. A young person with special needs who has a key worker might also be referred directly to support. A clear rule exists that a secondary age pupil wouldn't receive 'dual therapy' i.e. private therapy or through CAMHS as well as in school, but might access the in-house services to enable them to receive some support whilst waiting for external services to be delivered:

HS: "because we know it takes time.. at least we can get them into a system of support".

6.4 Resource Allocation for Mental Health and Wellbeing

Both Head teachers had made a clear decision and allocated budgets to subsidise or provide free therapy for pupils in need:

HS: "it's free of charge .. we'll do a six week cycle [monitored at the beginning and end of the period of time] and at the end if somebody still needs therapy.. and it's really quite significant, then we'll talk about referring them on".

PS: "We've got a psychotherapist that we employ. Unfortunately, recently we've had to cut the hours because the funding is just not there but parents [who are able] continue to pay, some pay, some don't depending on their financial circumstances…but we host it here, so children don't need to go off site to see counsellors."

The PS head had made a clear decision that where learning difficulties impacted a child's wellbeing it was more effective in terms of identifying problems and developing appropriate interventions to 'fast track' a child for an educational psychologist (EP) assessment using the commissioned services available to the school rather than to require a parent to seek outside support (an issue raised by a number of parents who spoke about having to initially identify then pay for an external assessment before a school or CAMHS would take their concerns seriously). In this way a child can be assessed and begin to receive assistance more rapidly, enabling them to achieve support effectively and to halt (where possible) deterioration in education or emotional and mental health.

> "we predominantly pay for those assessments. Every now and then, if it is a child who's presenting with concerns, but it isn't affecting their education, per se, we may ask the parent to pay for that assessment, because we've got a waiting list of children who are educationally in need, as well as emotionally in need….. I haven't got the money for it, I spend way more than I've got budget for, but what we have learnt over the years is, without that report, we're never going to get any EHCP, and never going to get the funding. So, we take it as a loss leader, but because it's £600 per child to get a basic EP assessment, that's acceptable for the local authorities to use for an EHCP referral, but it's fundamental if we're ever going to have enough evidence to show that they need services. And, the waiting list for CAMHS is just so horrific, that we need to accelerate them up that process"

6.5 Working with Parents Around Mental Health Concerns: a whole-school approach

Both Heads also retain a list of approved and trusted individuals to whom they will refer parents where concerns exist. This is in stark contrast to the experiences of some rather desperate parents we interviewed who spoke about receiving no help from schools and having to undertake a process of 'trial and error' to find a private Educational Psychologist to obtain an assessment before CAMHS or schools would take concerns seriously, even where a child was seen as being very disruptive or 'difficult', perhaps at risk of school exclusion or where their behaviour was impacting other children in the family who themselves began to exhibit poor mental health.

> "I have worked over the years with a variety of therapists, so I have three or four people that I think are brilliant. I know that you could turn up and somebody who I think is brilliant doesn't work for your child and what have you, but I will often – I'll say, "You know I think I should refer to you, or to you, or to you," .. I'll say, "If you want someone who's a bit like this, then try them. If you want someone who's got this kind of personality, try them." HS

> "[we have] a whole list of counsellors, therapists and assessors that we've worked with over the years. When the family come in and say I think my child needs looking at by someone but the doctor won't do anything, then we refer them… based on what we know about the child and family" PS

This personalised approach which seeks to combine well established routines for monitoring the well-being of pupils in school, combined with delivering tailored support which is reflective of the individual child's needs backed up by use of both internally funded and supplied and external support mechanisms, appears in both cases to be part and parcel of a leadership style in which Head teachers seek to ensure that the school is a well-defined entity with enforceable but fair and well-established boundaries.

> "Actually, first of all schools are here to teach kids and the reason why we care about mental health is so that they can access an education. It's not because we're going to be their therapists and their social workers, although having in-house provision can be helpful at a time where it's so difficult to access [statutory provision]" HS

It was clear that for both Heads not only had a deep personal interest in and commitment to the mental health and wellbeing of their pupils but also maintained expectations of a well-connected home-school relationship with clear rule setting and boundaries so that both parents and children are familiar with expectations.

It was emphasised by both interviewees that the school and those in it had a clear role in 'modelling good behaviours' and using both secular and religious education to support such learning; whether in relation to engagement with children, parents and colleagues, or in opening up difficult discussions which parents and, indeed (see further the literature review section on a 'Jewish specific context') broader community members might be reluctant to have, in relation to mental health, modern pressures and/or behavioural concerns. Both Heads actively facilitated (or hoped to find a way of facilitating) support services (over and beyond individual therapy) for parents and pupils experiencing difficult circumstances to create a holistic and supportive environment:

> "We also have a sibling support group, which Year 12 girls set up for girls who .. live with a sibling who's disabled. That's really different. They set that up, and the students are really fantastic. They meet once a week or once a fortnight … they just run a session about what's their home-life experience and sharing because obviously there's understanding there, which is great. But again, we had to be sensitive [in advertising and networking the group] I think that's been very important for them because often the focus is very much on supporting the disabled child [not other family members]" HS

> "[we offer] a course and it is about how do you manage yourself and your children in times of anxiety out of school. Running parallel to that, we also - and this is really important to our parents with children in challenging circumstances - we have a parent support group, and our parent support group meets termly. And, all children with SEN, or any need that's being presented, parents are invited to join it, and what we find is, those parents create friendships, and have similar issues, and signpost each other to services" PS.

> "What's really interesting is support groups for girls with eating disorders, because, as I said, that's still really secretive, you get parents to traipse to the other side of London for support, and then they pitch up and they see someone they know from round here.…There's got to be some way for a secret fraternity of people who are able to meet – we could facilitate that for parents here, but some people are just so secretive about it" HS

Another clear theme which emerged was that both Heads insisted that there were expectations and clearly defined boundaries and penalties for breach of regulations in

the school context. These were more to do with the impact of behaviours on others, and how a young person could develop in their life, rather than pertaining to externally motivated 'social appearance' or adherence to community mandated expectations of how somebody should behave or to what they should aspire.

> "I try and talk to them about Viktor Frankl, about purpose in life and Man's search for meaning and how do we find meaning in this world? I think that's partly what's missing with a lot of these kids. They're not sure what their purpose is and they're not sure what their meaning is, and they're not sure – they don't know what's the point [of being] here?" HS

> "[Getting children to understand that] I can't make relationship with anyone else, unless I understand how I affect others.. How do I present myself to others? How good a friend am I? How good a person am I? Then, how do I make a relationship, how do I become part of a team, and what's my role within a team, where do I best fit? Am I a leader, am I not a leader…? How do I make friends again when I've fallen out with them? But, equally, how do I accept that I have a conflict with someone, as you would in adult life, and move away from it, and that's okay? And, children understanding that we don't get on with everyone in the world, and that is okay, which we think is really key to their mental health" PS.

As such there was an emphasis in both schools on providing the opportunity to safely and appropriately 'question' (for example in religious education, or in relation to issues which parents may – particularly in more Orthodox families – be reluctant to discuss). Alongside this openness interviewees also articulated that there were a set of regulations and controls which required parents to actively engage with the school and their child's wellbeing such that it could be difficult for a parent to disregard or disengage from concerns raised in or by the school.

For example, in the Secondary School if a young person had been known to self-harm and an incident takes place on school premises then their parents are required to take them for medical treatment before the child is allowed back to school.

In the Primary School context there was also an emphasis on whole family engagement "more often than not, when a child is presenting at school, or at home, when we get under the skin of it, it's not about their learning, it's about family, and about parenting, or lack of parenting, or over parenting. And, actually, the parents and the siblings need as much work as the child, and so we often refer on when it's a family case [to Norwood or the Tavistock]" PS.

6.6 Parenting

The theme of the challenges involved in ensuring that (some) parents behaved in an appropriate and cooperative manner emerged strongly in both interviews and also within the focus group (see below). Given the prevalence of this theme in the focus group it is only touched upon briefly here. However poor parenting skills were a matter of deep concern to both of the Head teachers interviewed:

"Parenting the parents. I don't know if parents are less able, less well-equipped, nobody ever has a training session to be a parent before their child is born, so why do we think that some people are more or less able to manage situations and manage peer-pressure and support for their children? So, there are some people who inherently perhaps also grew up with poor parenting, so they don't have a good role model in that. Are there more working mothers, or families where both parents are working than there were six or seven years ago? Maybe. Does that have an impact? Maybe. Are parents themselves so now immersed in social media that they're also not interacting with their children?" HS

"The biggest thing is the partnership with the parents, I mean, I think that's crucial, because you can't go anywhere without that, and that's why we have to build strong relationships… the hardest cases to deal with, from our side, are the ones where it's the children presenting with family neglect. And, when I say neglect, it's not, we're not feeding them, they're not being washed, they're not being cared for, it's they're just being ignored" PS

6.7 Stigma

The theme of stigma in relation to acknowledging mental health concerns and eating disorders (particularly amongst the strictly Orthodox where marriage prospects might be impacted) or somewhat less stigmatisingly, acknowledging that a child had learning, or behavioural issues, were again highlighted in these interviews and explicitly linked by both Head teachers to poor parenting and the risks of exacerbating 'ill-being' for young people. Given that this subject emerged clearly in the focus group and amongst parents and young people themselves during interviews, it is indicative of the importance of communal leaders seeking to engage with the subject of self-presentation; communal expectations and breaking down stigma to enable healthier community practices and discussions.

"We know the parent can't deal with it and is pretending that there's nothing wrong, or they'll sit – we've met them a few times and it's now – the problem is, it's limiting the child's ability to function in school and therefore in the future. Sometimes I think where there are real difficulties, or perhaps family history, there's a real issue of stigma there, and that's hard because the child is not getting the help they need" PS

"So there just needs to be a collective communal approach to this [mental illness], that this is everybody's problem, it's not just the school's problem, and it's not individual families. Because to break the stigma it's got to be something that is now talked about" HS.

6.8 Social Media/Calibration of Risk

The theme of the dangers of social media which were discussed at some length in the focus group also emerged within both of these interviews. Obviously within the discussions differences exist in approaches and concerns given the ages of the two groups (primary and secondary) and indeed the more Orthodox nature of the Secondary School when compared to the 'central Orthodox, United Synagogue' affiliation of the Primary school.

For the Primary School Head:

> "the device culture has not helped, [pupils] are being parented by device, and they don't really have conversations, they don't feel like they interact…. they might eat meals together, but they might all be on their phones. It is that whole [situation], the lost child within a family, we get more of that, I think, in our community, and impact of family breakdown, than anything else"

Amongst Secondary Age pupils, particularly those who came from more Orthodox homes where they might not have access to a computer or television, the dangers of engaging in risky behaviours through illicit or unknowingly unsafe social media activities were a cause of particular concern to the Head teacher:

> "So we see much greater issues of social anxiety, depression, which we know is sometimes reflected off the back of, 'Everybody else's life is perfect on social media and mine isn't' So kids are losing the art of what's real and what's not real".

Furthermore, as discussed further within the focus group, amongst secondary age pupils the issue of sexting and pressures to behave in a manner which "goes far further than a snog behind the bike shed as it did in our day" were also facilitated strongly by the culture of access to smart-phones and being IT active at all times leading to a reduced ability to calibrate risk.

> "we're talking about kids having much more [IT] access at a younger age, so they get the privilege without the responsibility". PS

> "in the more religious communities, there's a lot of secrecy. If a girl is told no to everything, no boys, no internet, no smart phone, the minute she uses a phone, and nothing happens to her, she's got no – there's no graduated level of what 'no' is. If lightning didn't strike, then yes must be yes to everything as well" HS.

In summary, the two interviews with Head teachers from schools located at different places on the continuum of religious orthodoxy, varying significantly in terms of size of the school and age of pupils, but both of which are recognised as pursuing a vigorous policy of whole school wellbeing and mental health engagement, demonstrated a remarkable similarity in approach.

Key to this is a proactive stance which seeks to engage holistically so that children's wellbeing goes beyond educational achievement. To support this holistic model, a wide range of staff within the school receive training in mental health and wellness, and there is a clear approach of committing financial and practical resources to supporting students and wider family members. Whilst both Heads acknowledged that there was always more that could be done to enable an integrated and accessible model which impacted mental health across the school community, and one spoke openly about the changes they had made in their counselling services to ensure that these became more accessible to young people (discussed in more detail within the focus group in which they also participated) the interviewees modelled a reflexive and critical approach to the multiple dimensions of wellbeing in a school setting. For both, the Jewish school was seen as one part of a multi-dimensional community asset/network in which parents, statutory sector agencies; Jewish organisations – to whom they referred parents and pupils on the grounds both of cultural familiarity and also in full awareness that unlike statutory services, facilities and provision could be fairly easily accessed within a relatively short time-frame - were all partners. Rabbis and senior communal figures were also highlighted as necessary parts of the whole picture of community support, with an emphasis placed on the need to engage all sectors of the community to work alongside educationalists to enhance the wellbeing of CYP.

Whilst referrals were made routinely by school staff (following a set of protocols which sought to obtain an overall picture of the circumstances of the child in need of support) to Jewish agencies, for example Norwood or Noa Girls, and training and services delivered in school often emanated from communal organisations, there was a clear recognition that this was not the only - or necessarily always preferable model - for accessing help for a CYP. Not only were some statutory services – for example the Tavistock and CAMHS at the Royal Free Hospital, highly praised for their service delivery and willingness to support and work with schools:

> "I would also say that I have been able to work very closely with CAHMS at the Royal Free, they often give me very good advice… We have …just adopted a self-harm policy… the model was written by the team at the Royal Free. We've just slightly tweaked it and adapted it for us.. [following an increase in cases of self-harm] I started to talk quite a lot to the Royal Free, we did a five-week session where we had a therapist who works in the NHS and also at the Tavistock. She came and gave a lunchtime session to staff, and she built something bespoke for us". HS

but it was also identified within the focus group with education specialists - that some parents (and older children), at times preferred to seek help away from "the establishment" or "Jewish bubble". This was at times both through a lack of trust in confidentiality where individuals or networks were seen to be too closely embedded into daily community life, or simply because of fear of stigma (predominantly for teenage female pupils from more strictly Orthodox backgrounds) as concerns were frequently articulated by CYP and their families that someone would be recognised by neighbours, friends, or members of their community if seen accessing a specialist mental health or eating disorder facility and that individual or family reputation would

be damaged. This theme of the need to preserve privacy and avoid others knowing about the mental health needs of a child arose too in interview responses from young people; some parents, and agencies, overwhelmingly those working with the more strictly Orthodox communities (see also literature review materials discussed in Chapter One).

Again both Head teachers were clear about the need to ensure wider school and community discussions around mental health and wellbeing, embedding knowledge of such issues into the curricula and ensuring that wellbeing became an 'everyday' conversation.

Finally, as explored in some depth within the focus group, it was highlighted that there is a significant need to work with many parents around parenting skills, to ensure that they recognised what was, and was not a mental health or learning disability problem, as well as gaining greater awareness around their own boundaries and acceptable responses to problematic behaviours or concerns.

Despite offering praise to some individual CAMHS services, both interviewees were critical of the delays associated with accessing statutory services, with the Head of the Primary School in particular noting that CAMHS and support under an EHCP varied significantly depending upon the Borough or area (mentioned by an interviewed parent) from which children came:

> "Hertfordshire, for example, won't give any hours in a statement, won't make referrals and, therefore, you know, Barnet looks great in comparison. I mean, none of them are operating fast enough for the needs of our children, children are not getting seen quickly enough. So, we had a child who was privately diagnosed as ADHD, and it took a year for CAMHS to still see him, after a diagnosis, on medication, it took a year for CAMS to take that on, when the parents were saying, he needs a medication review. …and, Hertfordshire, though, are not seeing a child who is non-verbal, and he's absolutely desperate to be seen, for two years, at the age of four".
>
> The above themes were all also reflected in the discussions which emerged in the mini-discussion group and focus group (outlined below).

6.9 Group Discussions

In advance of the focus group with key schools-based personnel (see below) a mini-discussion group was convened by a member of the JLS advisory board within a PaJeS mental health day. SENCOs (4 participants) from three primary schools took part in a 20-minute group discussion with the convenor. Themes from the group discussion were then used to further inform and develop the approach towards identifying themes for the topic guide and exercise in the Focus Group which occurred a week later. A summary of the outcomes of the mini-discussion group are included below, and it can be seen that these mirror findings from the wider survey and those emerging in the two interviews with Head Teachers, all of which proved to be core themes within the focus group.

Participants were asked to outline their in-school structure of support for children with potential mental health, learning difficulties or wellbeing issues; challenges to supporting children in school; and what they would want to see to enable their wellbeing and mental health service to function most efficiently if money was not an option:

Primary School 1 [Manchester based]:

Staff employed/activities: SENCO; play therapist; art therapist; Occupational Health.

Would really benefit from a directory of services available, both state and private.

They were not aware of services such as 'Grief Encounter'. Felt that there was a need for recommendations for bereavement and divorce counselling. They would like to see structured, obligatory parenting courses and more resilience courses for pupils.

Primary School 1 [London]:

Staff employed/activities: SENCO; Heads Up (Norwood) training; social skills group; Pyramid Club (Norwood)

Importantly, all parents MUST attend a parenting workshop before their child starts school. They have set up a co-written Parents' and Childrens' Charter at the start of the year in which there is agreement over boundaries and respect for each other.

This school representative felt that there is a need for more training in mental health – particularly to develop a whole school approach.

Primary School 3 [London]:

Staff employed/activities: SENCO; wellbeing assistant; social skills group; play therapy; anger management and 'e-safety' days.

It was noted that particularly within a private school, children are put under huge pressure to succeed, often beyond their natural ability. Parenting styles have changed in the last decade. Children cannot [have not learnt] to deal with failure. Parents intervene at every problem, leaving children unable to deal with their own issues and challenges. Lack of respect for teachers from children and their parents leading to mental health issues in teachers. For example, parents emailing staff late at night and expecting a response immediately. Parents often are not role modelling good behaviour.

As can be seen the themes of parental behaviour/expectations (and impact on staff); the need for additional training for staff on mental health (and enhanced knowledge of available resources) were again all strongly emphasised, a finding which is common to all educational responses whether from survey responses or participants in interviews or the focus group.

6.10 Focus Group

The topic guide and exercise used to lead the discussion within the focus group are included within the Appendices to this report.

The initial stage of the focus group consisted of a request for the six participants (One Head Teacher; One Deputy Head; three SENCOs and a Pastoral Lead from a total of two primary schools and four secondary schools) to list on post-it notes as many 'challenges' to supporting mental health and wellbeing in their schools as they could identify and to then repeat the exercise in relation to 'priorities' and 'concerns', placing their post-it notes on whichever headed sheet (under the three categories) they felt was most appropriate.

The sheets containing themes were displayed on the wall (see photographs below), then the concepts grouped under key headings which formed the basis of discussions within the focus group. The illustrations below demonstrate the thematic and methodological concepts and approach used and the clustering of issues. Findings and discussions from the focus group are then presented under the sub-headings below, which illustrate the core concepts which emerged and were agreed within the group debates.

Image 1 – Challenges around supporting mental health

Anxiety

It was noted within the focus group that the blanket concept of anxiety was frequently misunderstood and misused by parents and children, perceived of as an automatic trigger word requiring action to be taken:

> "It is used all the time. Kids use it all the time, parents use it all the time and they have to actually … Anxiety is a good thing. It helps you. If you are anxious, it is not always a bad thing. It is part of your emotions, part of your make up. I think parents very quickly think, "Oh, my child is anxious. I have got to take him to this one, that one, get more help," whereas if only the parents would spend more time with the children to understand and not just pass it straight to the school: "right you deal with it" … at my school, we don't have a counsellor. And that is the one thing that the parents want, is a counsellor". Pastoral Lead – Secondary School

It was agreed by all participants that parents are often lacking in knowledge of what are or are not 'normal' emotional responses or when and where concerns should exist in relation to a child's mental health or wellbeing.

Accesses to resources and 'time' and 'space' – quite literally for some participants in small schools with limited resources there was a lack of physical space or time to engage "in privacy" with parents and children. Larger schools with specialist pastoral teams were in the main afforded greater access to opportunities to explore mental health concerns although pressures on individuals and resources were also noted. For example, "high waiting lists" were seen as a difficulty by some individuals as not only pertaining to external services such as Educational Psychologists and CAMHS but also to see "the school counsellor". Resource pressures to enable staff to obtain suitable and adequate levels of training on CYP mental health needs were particularly of concern for smaller schools, whether secondary or primary establishments.

Training and awareness raising in types of mental health and learning disabilities as well as warning signs – both for staff members and also for parents - featured as a high priority within discussions on several occasions within the event.

> "parents contact … email the school and say my child has got mental health issues and they want to be heard and they want it dealt with..."

> "but how do they know [the child has] got mental health issues?"

SENCOs raised the issue that in a highly academic and competitive culture such as is common in Jewish schools, both parents and teachers might assume that a child who was not thriving academically, automatically had special needs

> "not so much parents but when the teachers constantly come up to you, "I am worried about this child, this child and this child" when they are not necessarily a mental health [risk]. They are just a low ability child and they [staff] want you to then take the child on"

> "there seems to be a bit of a disappearance of the basic role and responsibility of the classroom teacher. If it looks like something is difficult to manage, well, we can pass it on to someone [SENCOs]".

Connected to the concern about training and awareness of mental health and learning disability, was the **issue of communication between different departments of a school** and external agencies. Whilst some participants indicated that working in a smaller school might facilitate communication between staff, a potential lack of formal regular wellbeing meetings could also mean that information wasn't always as effectively shared as was desirable. Similarly, in larger secondary schools whilst clear protocols were in place and there was a greater likelihood that a multi-disciplinary team existed to support a child, it was flagged up that where only initial limited concerns existed about a child that they might not initially be identified as being at risk:

> "we've got so many different departments and teachers.."

> "we have all got [IT system] and we put things onto [it] but if there are certain things that we want to discuss between ourselves that maybe you don't want to put on an email or something… it is very important to have 'face-to-face' [meetings] but it is that challenge of where has the day gone"

The issue of having clearly timetabled regular meetings was regarded as important so that pastoral leads could meet with SENCOs, counsellors [where a school had an in-house counsellor] and other senior staff to discuss concerns about an individual child.

Smaller schools were more likely to meet informally in relation to children of concern, or class teachers were asked to find time to look at reports and discuss specific situations which had been flagged up as requiring monitoring.

The Role of Teachers/Staff. In common with a theme flagged up by the Head of the secondary school who participated in an individual interview (above) discussions emerged over whether staff should be being more proactive or reactive when an issue is initially identified.

This links closely to a number of debates throughout the focus group on how teachers and support staff roles have expanded, adding stress to a busy, difficult, daily working life and the theme (above) of the necessity of receiving specialist training. One participant noted that

> "if you spot something, some people would just ignore it, some people react to it and some people - it is almost like spotting the signs first. So, if you could spot the signs, then you could be proactive before it becomes such an issue that you have to be reactive"

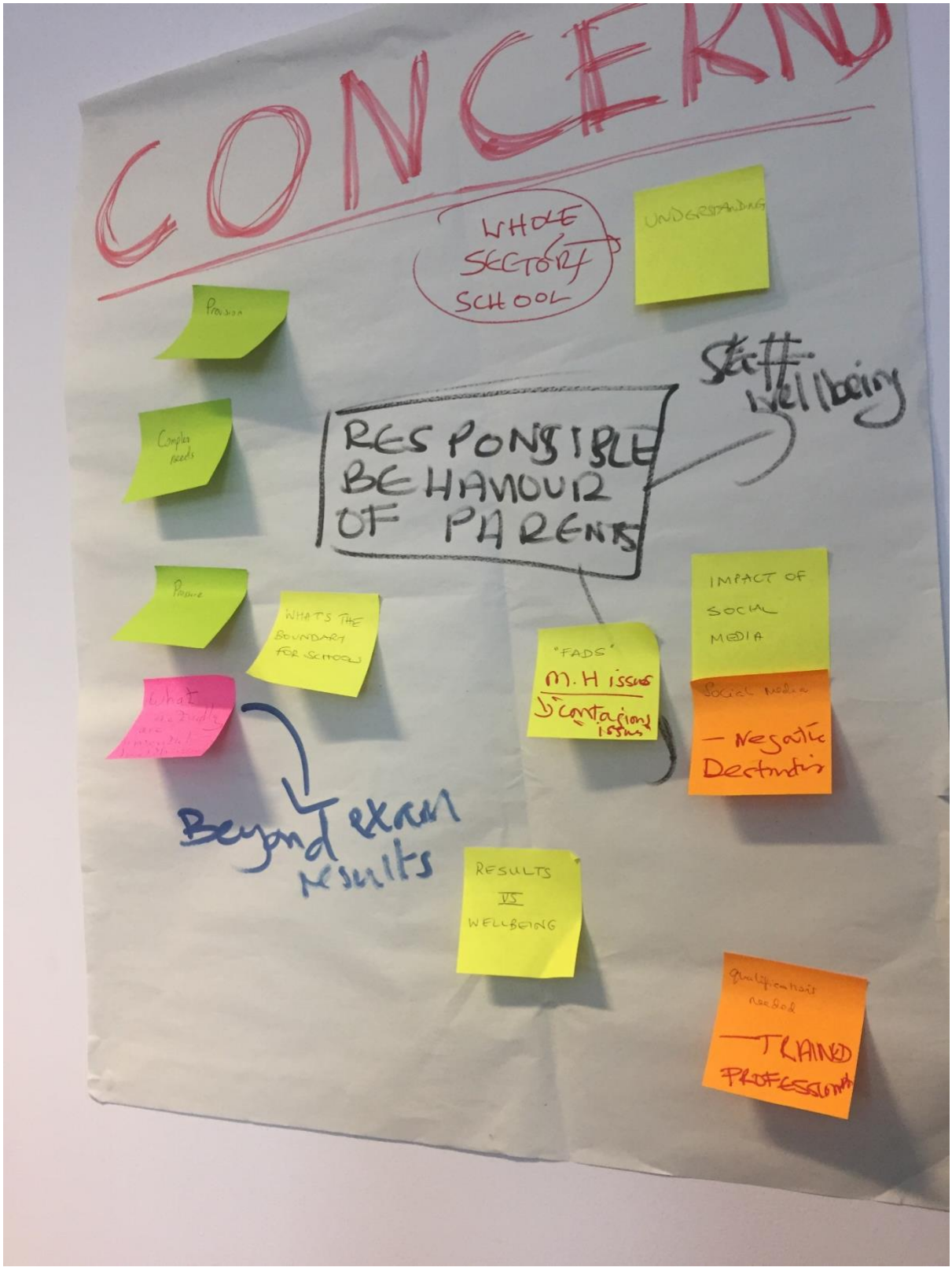


Image 2 – Concerns around supporting mental health

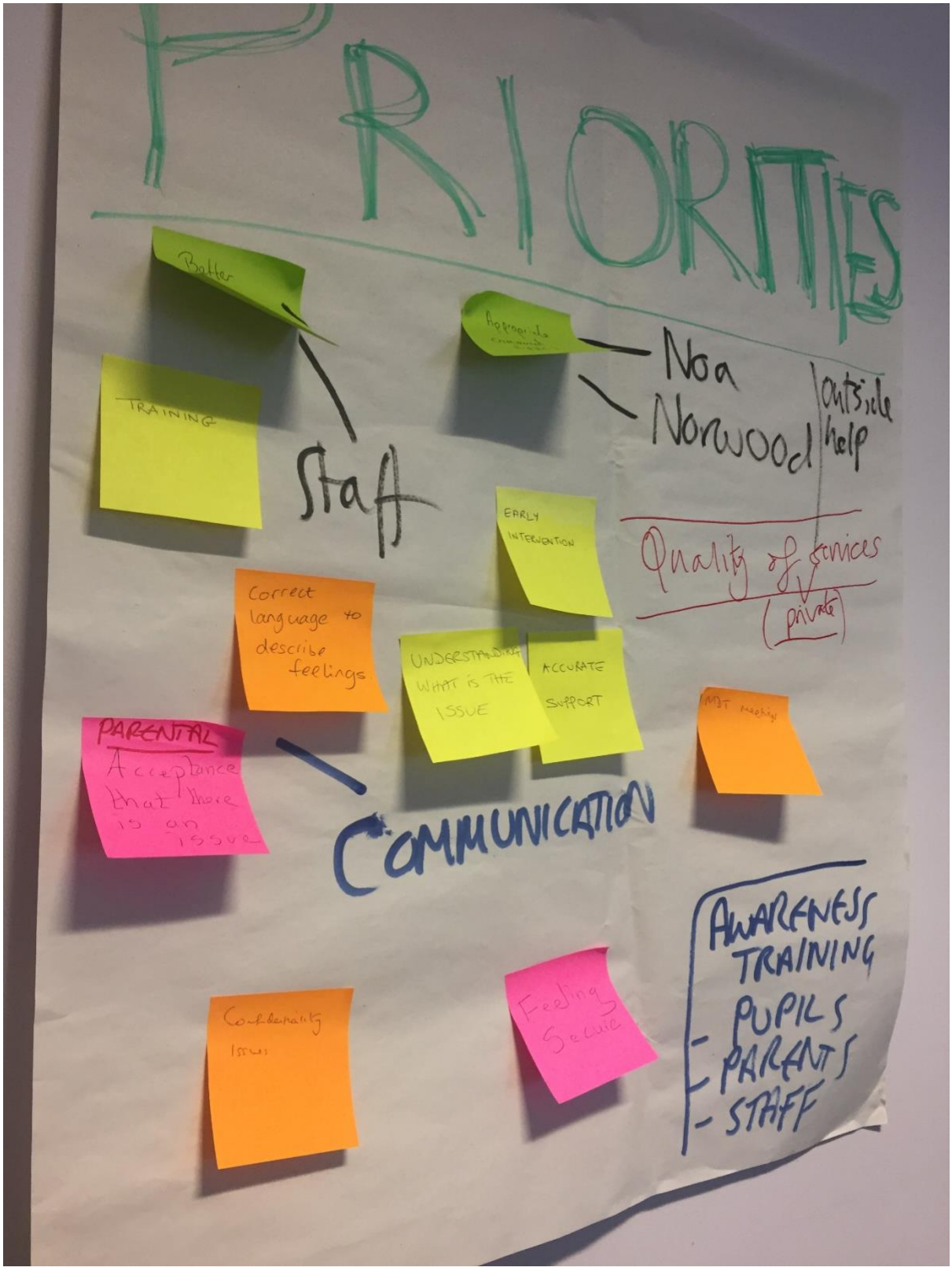


Image 3 – Priorities around supporting mental health

Both Concerns (how to engage with issues and what it was felt required more school, individual and communal action) and Priorities, were largely debated together and for convenience presented below in one discussion section.

The core 'priorities' identified by participants in the focus group shared a number of overlaps with themes listed under both 'concerns' and 'challenges'.

The key clusters of priorities were focused around **'training' on recognition of mental health concerns (again for staff, parents and also young people**), 'engaging with parents/parenting behaviours'; 'signposting to external services' and 'unsustainability' without access to support, in which section the theme of practical constraints, space, time, finances and communication between departments were once again flagged up.

Better (and more) **training** for all members of the community and in all roles, was regarded as probably the highest priority, attracting universal approval.

The need for **stronger communal provision and greater sharing of information** was also afforded significant attention. Participants highlighted that a number of key agencies and organisations from within the Jewish community were well known and respected and widely used. These were predominantly Noa Girls and Norwood. It was pointed out that for Orthodox boys there was no equivalent service to Noa Girls to which they could be sent and where holistic support could be offered.

Interestingly, in common with findings from parents' interviews and that of young people, Jami did not feature as a resource which provided services to young people. Norwood was also identified by one participant (a SENCO) as only offering "social work teams as opposed to mental health professionals". Moreover, it was felt by another speaker that Norwood "don't like getting involved in certain things [unspecified]"

Similarly the work of Legadel[40], known and highly commended by one participant as supporting children with learning difficulties which were not severe enough to attract statutory support but which risked disrupting education and potentially causing anxiety and/or mental health problems (see also Chapter 1 literature review for a discussion on learning difficulties), was only known to the convenor of the workshop and the SENCO who had worked with them.

The debate around the value of communal over statutory service provision necessarily touched upon issues of **stigma and fears over confidentiality** with one participant noting that:

> "We always have some parents who don't want to go to a Jewish organisation, because they claim that they are too nosy, and everybody knows everybody else and they want outside help, external help outside the Jewish framework".

[40] A strictly Orthodox learning support organisation set up by parents for parents which is working with a number of schools, funded by Pupil Premiums or through school budget prioritisation to deliver specialist input from psychologists and special education experts

The **stigma around mental health difficulties amongst the most Orthodox families** excited considerable comment from staff who were either currently, or had previously, worked with the most Observant families:

> "I was going to say we have had the stigma with more religious kids. There is a stigma attached to mental health needs, because it is about their shidduch prospects and we have had those experiences, for sure, [both boys and girls]"
>
> "Not only their [shidduch prospects], their siblings as well".
>
> "They don't want anyone to know. If it ever gets out…"

Speaking more generally about parental concerns (not simply within Orthodox families) one speaker noted that:

> "The other time you don't hear [about a child's mental health] is when along the way you discover that the parent had a mental health issue and they are so terrified that you will find out that the parent had an issue. That is why they don't say because they think it is their fault their child has an issue".

All participants (and in particular SENCOs) when speaking both of primary and secondary age children noted that **parents were often in denial about either learning disabilities/autism or mental health problems** linking to discussions outlined in the literature review and by young people in their interviews around competitive parenting and difficulties in accepting that a child wasn't academically inclined:

> "Particularly with the young kids….there is clearly a problem and they cannot get the parents on board and all the time is going by. It is almost internally - a parent, if they acknowledge it - they feel like a failure because they haven't produced a perfect child".
>
> "Where their child so desperately is in need of some help and support and it is the family blocking that, for whatever reason, really persuading them to buy into that. It could be a whole academic year that a child loses out because you can't get a parent self-referred to Norwood"

The Assistant Head of one large secondary school noted the tendency for parents to use a range of external (privately financed) services, reporting that they would in fact prefer it if counsellors or therapists were provided in-house through schools or accessed via agencies such as CAMHS as they were concerned about the **quality of (private therapy) services** and communication routes when parents sought external therapists. They noted that without an awareness of the school and other settings a private therapist might make unsuitable suggestions. Whilst stressing that confidentiality in relation to content of counselling should be preserved this participant noted that:

> "My issues as a school is when parents start going private, I don't know who they are going to, and then they try and a) do it during school time, which I never accept because they can't go privately during school time, it creates lots of issues. You don't know what this private person is doing. At least when it is

> CAMHS, there is a bit of a communication tool that you can get hold of them, at least when it goes through a social service system as much as they change every two seconds. As a school, you can talk to them".

Continuing the theme of **communication between parents, schools and therapists (and also stigma** pertaining to certain conditions) another participant noted that

> "where people are most secretive has been around eating disorders. To the extent that they can barely actually tell me what the problem is, even though it is staring me in the face.. I've have had a few cases like that where I'm literally the only person in the school who knows even when the child is about to collapse".

Encouraging access to in-school resources/Counselling Services

Whilst not all schools represented (particularly smaller and more strictly Orthodox ones) did not have counsellors – and indeed participants felt that there was perhaps scope for clustering and sharing of provision, the larger secondary schools all provided in-house counselling.

A key theme, which emerged in relation to **encouraging take-up of counselling for pupils and students** who could self-refer for assistance; consisted of reassurance that counselling, was both confidential and that the individual would 'understand the young person'. Given the prominence in parental and young people's interviews of the theme of CYP's reluctance to seek in-school support, particularly where a counsellor was seen as being 'establishment' or 'old'; it was noteworthy that in two schools a recent change of policy had occurred, and in both, the recruitment of a counsellor who was perceived of as less Orthodox, younger and more 'in tune' with the concerns of CYP had led to greatly increased take up of services and willingness to self-refer.

A number of parents and young people who were interviewed and who recounted a strong sense of dissatisfaction with school responses were indeed reflecting back upon experiences in school which had happened a few years previously. In those cases, they generally indicated that they felt school pastoral staff or counsellors were unapproachable or did not understand their concerns, so these findings from the focus group are indicative of a shift in approach within schools which may potentially alleviate some of the barriers to help-seeking behaviours amongst current cohorts of students.

> "We had a rabbinic style counsellor. A qualified counsellor, but an older guy, bearded, and most of the boys weren't interested because they just saw him as a father figure. They saw him as an uncle and not really a professional counsellor. Actually, we were lucky enough to get a younger male, cool, relatable and my waiting list shot up, but they are actually seeing him".

> "Before, the previous counsellor…was a part of the establishment and she did not just counselling, but she was also running sessions and doing this and this. There has been a complete separation between now the counsellor and again, very fortunately, because it just so happens there is a wellbeing officer as well. So, the wellbeing officer is the one in the classroom doing these PSHE type

sessions and the counsellor has been separated from that. That two-prong [approach] I think has really helped with the trust".

Whilst an insistence on confidentiality and a clear separation between counselling staff and other teaching staff appeared to pay dividends in terms of accessibility, this could on occasion, as recounted by a SENCO, have consequences for communication issues between departments (see further above), flagging up once again the need for regular face to face meetings and agreement over protocols for record keeping within teams:

> "We are very lucky to have a counsellor. But nobody knows who she is seeing, including myself because she has decided that she feels that confidentiality is an issue. .. now, I think there is a feeling that if I am working with the same student as her she is happy to know everybody, and I am happy for her to know because I trust her, but there is a feeling there could be some replication here….I said to her, can I just hear who you are seeing, and the answer is no" (SENCO, Secondary school)

Discussions also took place around the **challenges of children accessing CAMHS services** (generally regarded as extremely difficult to access and with unduly long waiting lists and particular concerns over a child between the age of 16 and 18 being denied access to services)

> "16s to 18s are the biggest problem"
>
> CAMHS won't take them and other services won't take them.

There is a clear gap in provision for this age group which in-house counselling services may not be able to support for children in school, and if parental finances – or a young person's desire for privacy – preclude applying for NHS provided mental health support there is a potential for a CYP to 'fall through the net'. Accordingly, it is strongly recommended that communal organisations such as Jami, Norwood or specialist agencies utilised by strictly Orthodox communities such as the London Jewish Family Centre and Noa Girls should seek to develop provision further to meet this gap: with agencies working in partnership with schools and drawing down funding or developing provision under proposals contained within the 2017 Green Paper.

Two schools *without* access to in-house counselling mentioned (non-Jewish) resources to which they had referred pupils with some success: 'Signpost' in Hertfordshire, a free phone counselling service which also offered one-to-one access and which permitted self-referral. The services at Signpost were however believed to be under risk of cutback "so won't be in existence for much longer. But that has worked quite well". Kooth the online service was also noted as offering self-referrals.

In the case of one primary school:

> "we have a counsellor… she is there two days a week and the children can self-refer. As they are little they put their name in the box and then she will go and give them a card with a time to come and see her. We have found that

maybe because they are younger they don't have the stigma yet. It's worked very well. She will tell the head teacher specific things [if concerned] and the head will delegate if she feels it needs it"

6.11 Key Issues which are seen by SENCOs/Counsellors

In common with other elements of this chapter, the theme of **over-anxious, 'helicopter' or 'pushy parents' was prominent in this section of the discussion.** In particular:

> "A lot of children who are anxious – but often I find it comes from parents who are also over-anxious"
>
> "Parents who are very pushy and want their child to be Einstein when they are not going to be that".

This theme struck home, as all participants, working with children of diverse ages, had particular example to impart on the impact of parental ambition causing harm to children's wellbeing:

> "we had one parent who sat their children [entered for exams] for private school. Their child didn't get in so they took the child to a psychologist to see why"
>
> "exam stress.. one particular child the parents were really very, very pushy and you could see the anxiety building up and building up in this child"

The theme of poor quality parenting was also reiterated:

> "a fair number of working parents, they rely on nannies and au pairs .. and I think they just haven't got those kind of skills themselves, so the kids come in and they haven't got the [social] skills"

The important theme of how to best **support and celebrate the achievements of 'less academic' children** led to considerable discussion (see chapter 4)**.** It was widely felt that the over emphasis on the professions within the Jewish community could be particularly negative for children who were struggling – leading for example as above – to a 'search for an explanation' by parents. Not only did several participants feel that there was a need for presentations to children and parents of alternative pathways – vocational as opposed to academic – but also the use of materials which celebrated Jewish role models who had achieved in non-traditionally academic ways. Good practice examples were provided by some schools representatives, for example, presentations by former pupils at parents' evenings who had themselves followed technical pathways:

> "So, in the last few years, we've had a Prospective Parents Evening. We invited a parent to address like the formal presentation, and I carefully chose a parent a few years ago who had two daughters. One who had studied Physics and one who went down a vocational route, and because of what we were able to offer her, is now basically running her own catering business. It was brilliant

because it sent a message there that we can do that, but that's a language you've got to start developing with the parents from the minute their child steps in the school. So, that when they come in to choose GCSE's or B.Tech that they don't think that these are second-class qualifications. They see it as an alternative, valid pathway, and it's about bringing in people who have been successful, and perhaps young people that they can see who have been really successful, to show them that you can actually do it" Head Teacher

It was flagged up by several participants that there is a need for a **'6th Form' for non-traditional or less academic skills** – perhaps through connecting to a local college to deliver provision given that there would probably not be enough pupils in any one school to warrant each secondary school offering 'alternative education' routes. The discussion on how best to support less academic children excited considerable attention as a way of engage with well-being and offer recognition to young people of their achievements; as the exchange below illustrates:

"that might be a middle-class thing, it might be a Jewish thing, it might be a Jewish middle-class thing, I don't know. That actually, results are everything and our kids are living in a very exam-orientated society and we're not developing them as human beings because there's this if you haven't gone to university, you must be a failure"

"educationally within our community, we don't have very good alternative pathways"

"And we don't value it. So, we don't value our plumbers and electricians".

"I don't know if the JLC within the whole spectrum of the community, we could find a way of having something…."

"there might be something that we together as Jewish schools could do"

Supporting parenting skills and setting appropriate boundaries through the use of home-school contracts was of considerable interest to participants, as was the issue of monitoring whether and how notes about particular issues were read by parents – the concept of using online technology to do so proved of interest in terms of ensuring that parents kept up to date on wellbeing and mental health issues.

"you can hound them [parents]. Send them follow-up emails and see it's not been accessed"

"we need to be thinking creatively about how we are accessing parents.. instead of expecting them to come to us we need to find other ways to access them. These notes [of mental health workshops delivered to staff] should be copied and then sent to all parents"

6.12 Social Media – and pressures around appearance or sexual activity

Amongst staff working in secondary schools – even those serving the more Orthodox communities – concerns existed about the toxic impacts of social media, sexualisation and use of on-line pornography, and normalisation of extreme sexualised attitudes and behaviours.

> "young girls being pressured to behave or look or do certain things and be a certain way because of what they see on social media"

Amongst strictly Orthodox girls (as noted by several participants) this was seen as particularly dangerous, leaving young women at real risk:

Speaker 1:"because of that issue of not being socially acceptable, they are going behind parents backs to access social media, so they have not actually got any network to have the conversations".

Speaker 2: "And they can't calibrate grades of 'no'

Speaker 3: "There is no safety or internet safety because they just don't [have the knowledge].

S2: "Even if they have received [e-safety advice] at school"

S1: "Well, lots of the houses don't have internet"

S3: "But you educate them about what is out there. It is like it goes in one ear and out the other".

S2: "It is also that somebody said it is like roads with no speed bumps, and everything is instant and things you might have thought about doing, you might have stopped yourself along the way. You take a [indiscreet] photograph of yourself, years ago you would have to actually physically take the film out the camera, go to the chemist, worry that the chemist might see it … there were so many barriers along the way to actually disseminating that photograph, whereas today, you haven't even thought about it… ".

The impact on boys of accessing **pornography** was also debated by several participants and highlighted concerns about young men's attitude to women and girls being impacted by the normalisation of media exposure:

> "What it is doing is in their mind, it is normalising certain behaviours which actually then lead to so many other problems when they then have some kind of relationship because they have an expectation that isn't reality. There are all the issues around consent, and it just leads to a whole other problem"

> "We had a big situation. Well, it is not porn in the sense it was '50 Shades of Grey' [a film] that a number of the boys saw. Yes, it was an 18, and they were clearly not 18. But they were 16, 17 whatever. But it very much … the conversation you kept on hearing in the common room that we had to address was "all women want to get beaten, they are all into S & M. That is what they like". It is not porn in the sense of it, it was just a mainstream film…"

Social Media and 'contagious' behaviours. Following on from the discussion on pornography the debate widened out considerably into the 'toxic' impacts of CYP accessing 'cutting' or suicide websites. It was clearly recognised as an issue across all schools in the country and not confined to the Jewish population, or any particular denomination (although most common amongst girls). Significant debate occurred over whether a young person might be following a 'fad' or had significant mental health issues when they indulged in self-harm and how to differentiate the two.

Inevitably the issue of training for young people, staff and parents, as well as communication skills were once more foregrounded: The following exchange involved four different participants:

> "like belonging to a club"
>
> "I was going to say a gang"
>
> "they have competitions within self-harm. So they would .. I cut myself this many times, how many you done, mine are deeper than yours…
>
> "The whole Blue Whale [film about self-harm] was about doing the worst thing"

The issue of eating disorders (see above) was also briefly considered

> "there is no doubt that within the Jewish community and the Orthodox, the aspect of having to be very, very thin is really important. You see it in the mothers"

The negative impacts of social media on teachers well-being (poor parental behaviour) was also touched upon, as several participants recounted how "lies," "teachers not wanting to come into school" could occur as a result of toxic slurs being spread via parenting WhatsApp groups, or bitter gossip and complaints made if a parent or group of parents took against a teacher and in effect adopted bullying behaviours against her or him. Essentially it was noted that "negative and destructive group behaviours" could thus be found amongst both parents and children.

6.13 Concluding Debate

In the final section of the focus group participants were asked to identify key aims and themes which they wished to reflect upon as supporting good practice, or where the JLC and the community more widely could potentially act to develop **"good fads" which in turn would become "continuous language" which assisted buy- in to positive mental health and wellbeing:**

Prime examples offered by participants consisted of "mental health weeks run by the sixth form"… based on an earlier example of a disability week with

> "students representing different [conditions] they have.. ADHD; ASD; a boy in a wheelchair…"

A strong message consisted of the need to develop closer collaborations with a broader range of Jewish agencies – such as JAMI and Norwood etc. Although some (but not all) participants were aware of at least some of the services offered by these agencies there were clear gaps in knowledge for example in relation to the services offered by Legadel – discussed above. The issue of stigma once again came up in this section of the discussion

> "dealing with reluctant parents they don't want to refer to Norwood…. But it's going to be about a way of reducing the fear, if they could see a human face of some of these organisations they would be less scared. Norwood is just a name out there. If they could meet somebody from Norwood or had the opportunity to do so in a setting like a school where they feel safe"

It was collectively agreed that a combination of reducing fear and stigma and sharing information could be **developed by community leadership supporting schools and parents in building bridges, through the development of opportunities for school staff and community members to meet with communal organisations** in a non-threatening and non-stigmatising context:

> "maybe it should be like you go to an exhibition and have different stands there…"

> "there has got to a be a central place where you can go and see who's available…. A big event, a communal [event], a launch pad or even it becomes an annual event and all these organisations are there.. a way to go and know who all these organisations are"

Staff training and the need to support staff wellbeing

Good practice in terms of supporting staff wellbeing was highlighted as important in terms of developing understanding of wellbeing generally and also supporting staff who were often under remarkably high levels of strain. A particular good practice example was presented where the Head of a school which focuses on 'whole school' action around mental health organised a large scale INSET set day with a theme of staff wellbeing

> "because the message was if you can't look after your own wellbeing how are you going to look after pupils"

Activities included talk, workshops, activities such as Tai Chi, art therapy, meditation, participating in a therapeutic exercise etc.

The importance of staff being supported and appreciated by parents, PTA and each other was of some considerable interest "refreshments between the end of school and start of parents' evening in the staff room were paid for by the PTA as a nice little sign that says, 'thank you for working for our children'. It made people feel welcomed.

In contrast, one participant from a different school spoke about feeling really very disappointed and let down by colleagues and senior staff when they had had a

> "really horrible situation.. really difficult, even when I talk about it now it makes me want to cry… and nobody from school, even though they saw I was very upset, nobody phoned me except for one member of staff who saw me leave…. She said I got your number and I just want you to know that I'm here, but nobody else [mentioned her distress]"

In many ways this example highlighted the necessity of supporting front-line staff engaging with challenging, emotionally painful and difficult situations. Indeed this reflects upon a comment made by the Head of the primary school interviewed in the previous stage of the research who spoke about the need for the provision of '[therapeutic] supervision' for staff dealing with safeguarding or other difficult and challenging cases on a regular basis.

The fact that staff were often being asked to work outside of their main areas of training, acting more as social workers or therapists clearly hit a nerve with most participants. "we are teachers in school, we might have our own specialities, but we are teachers in schools" [not psychologists].

6.14 Training Needs

The final element of the focus group enabled participants to round up the event with brief comments on training needs. A strong sense existed that there was a need to provide training for teachers in engaging with challenges, priorities and concerns, as explored at length during the session.

Overall it was articulated that there is a need for "joined up thinking" and enhanced communication so that a child and parents are prepared for entering school; transitioning to secondary school and into teenage life and subsequent education or employment situation.

One secondary school SENCO noted:

> "we are seeing issues younger and younger… which means they are starting in primary schools so to give the children a warning, or the parents a talk about good boundaries in Year Six is far too late"

Another key point which was flagged up was the issue of going 'on tour' or gap years or making the transition to university. **Participants expressed the sense that there is a need for appropriate life-transition lessons**. For some [strictly Orthodox] young people who are "going onto be married within a year or two" they get a "session or two on relationships but there needs to be more about what does it mean to build a firm foundation".

For others, particularly young people who are likely to take on communal roles such as acting as **Madrichim** (a theme which echoed remarks made by two young people who were interviewed) it was believed to be fundamentally important that embedded, **high quality training** was delivered which incorporated recognition of mental health and wellbeing issues and included "Mental Health First Aid" – a concept which proved popular amongst participants in terms of roll out to a wider group such as 6th Formers more generally.

"I went to a training day [for Madrichim] and it was just appalling how poorly trained the youth workers were in the room and how little they knew and … we are sending our kids to these people and they haven't a clue. It was really quite shocking"

"I get very worried that the Israel trip… great people and really having to deal with kids in groups – that is very hard for them but… every year they have to deal with these issues"

"One of the experiences is that some of the youth movements, you get a problem because you have got a kid [youth leader] who are now having to deal with issues at an age when they just don't know how to"

Clusters of activity between and across schools – were strongly proposed so that there is a "mental health lead for a number of schools, and that person could be in a forum of mental health support". This suggestion was warmly commended as an affordable and practical concept which would particularly support smaller schools with limited funding.

6.15 Recommendations: Educational Sector

Whilst the far-ranging discussions within the focus group are explored in some considerable depth throughout this chapter (as are suggestions from interviews carried out with Head teachers and recommendations garnished during the survey phase) the following summary points can be identified as the most pertinent for immediate consideration:

- Targeted training for staff throughout schools – e.g. supporting and managing students with borderline personality disorders, identifying and differentiating between 'real' and 'fad' self-harm presentation, effective calming techniques, coping strategies for their own time management and work life balance
- More parental education to help remove a widespread stigma associated with learning difficulties and mental health issues
- Provision of more mental health and wellbeing services located within schools
- Regular training for all staff in relation to mental health and wellbeing
- Better signposting within schools to increase awareness about what services are available within the Jewish community as well as the criteria and routes for access
- Adopting a whole school/university approach to mental health and wellbeing
- Delivery of training for 6th Formers and Madrichim/Youth Leaders/Volunteers on Mental Health First Aid
- Recruitment of younger, more accessible counsellors who are perceived of as being 'less establishment' and with more in common with potential service users/pupils
- Development of closer working with parents – potentially through co-designed parenting contracts and expectations on parents in relation to wellbeing
- Closer liaison with statutory agencies such as CAMHS

- Development of communal services and to ensure that these are de-stigmatised through the development of trust and familiarity in relation to services potentially seen as ‘scary’ to access
- Need for whole-community discussion and engagement around mental health and wellbeing which is embedded in conversations, curricula, activities so part of normative conversations
- Recognition, celebration and support for less-academic/vocational routes so that CYP who are not proceeding to university or who are not achieving at high academic levels are not seen by peers and family as ‘failing’
- Development of a recognised pathway for vocational routes for Jewish students – perhaps located in a single school or college
- Enhanced awareness amongst parents of the dangers of focusing on academic achievement at all costs – and reflection on their own behaviours and parenting skills
- Development of cross- and inter-communal mental health and wellbeing provision for 16-18 year olds and enhanced publicity about the network of services which exist
- Further research into the support needs and challenges faced by Jewish university students in the light of alarming increases in mental illness across the sector and limited representation in this study
- Support for school staff wellbeing in the light of increased roles and the requirement to support more CYP with mental health and learning difficulties
- The development of clusters of activities across and between schools such as SENCO mental health forums and mental health leads for clusters of schools which are not large (or well funded) enough to employ a specialist wellbeing/mental health coordinator.

Chapter 7 –Young People (ages 18-25 years) and Senior Youth Agency Coordinator

This chapter consists of findings from the five interviews undertaken with Young People aged between 18 and 25 years and also the interview with a specialist youth service coordinator which was undertaken following a survey submission received from an organisation. The survey response from the youth agency/education network, whilst included under the analysis presented in Chapter 3, was followed by an in-depth interview which most appropriately is included within this section of the report.

Although considerable efforts were made to access a larger number of young people for interview who either had personal experience of accessing mental health services or who were in a role in which they had contact with CYP who might be at risk of developing poor mental health (for example those working as youth leaders/Madrichim who accompanied young people 'on tour'), this proved difficult to arrange.

We were supported in accessing the young people whom we interviewed (a mixture of face-to-face and telephone interviews) through key specialist agencies who are in contact with young people and who (in the case of several face-to-face interviews) provided us with a 'safe space' in which we could meet our interviewees. Although a number of young people indicated their willingness to be interviewed, sometimes repeating this willingness on more than one occasion, when re-contacted at a time of their choosing to confirm interview arrangements, it typically took several attempts to receive a response from them, by email or telephone. Indeed, other than when directly arranged/facilitated on our behalf by specialist agencies who were able to organise that the young person using their services would be at their offices at a specific time to meet with us, in the main these category of interviewees proved the hardest to reach.

Essentially therefore, the difficulties in obtaining interviews with young people tends to support the statements made by a number of the respondents to the surveys in relation to difficulty in engaging young people in accessing services or in some cases even finding an appropriate way of entering into discussions around mental health and wellbeing. The findings from the very rich interviews we were able to undertake have however proved invaluable to this study. The table below provides basic demographic information in relation to the young people who participated in the research.

Table 12 CYP Interviewees

Gender	Age	Service User	Services Used	Religious Identity (where provided)	Youth Worker/Madrachim
F	19	Yes	Specialist Jewish Support (SJS);	Modern Orthodox	No

			CAMHS; Social Work engagement, Tavistock clinic		
F	24	Yes	SJS, CAMHS	Mainstream Orthodox	No
F	18	Yes	SJS; CAMHS, Tavistock (waiting list)	Strictly Orthodox	
F	20	No	Many friends having used private therapists	Reform	
M	21	No	Aware of many young people using therapeutic services private and via university	Masorti	Yes

In addition, as noted above, an interview was carried out with the coordinator of a cross-communal/inter-denominational Jewish youth agency, working nationally to provide support to a range of 'chalk-face' agencies rather than providing direct services.

7.1 Over-arching themes – summary of the interview/survey response received from the youth education coordinator

This interviewee indicated that based on their personal experience, and reports from network members, the main concerns impacting CYP within the community consist of anxiety and depression; gender identity and sexuality concerns; eating disorders; self-harm and substance misuse, as well as family mental health issues; school pressures and online bullying. They also highlighted in particular the endemic levels of 'low level anxiety and depression' which underpin all other concerns, as well as the impact of increasingly levels of divorce on young people. In addition they explicitly noted referrals made to 'Grief Encounter' for young people following a bereavement (stressing that they are made aware of/had contact with many families/young people requiring referrals following bereavement) as well as other communal/statutory agencies such as Noa Girls, Jami, Norwood, JWA and CAMHS.

Within this interview, considerable discussion took place about the impact of academic and family pressures which can create a toxic situation for young people who do not conform to expectations or norms, leading to mental ill-health. Comments also borne out by the young people to whom we spoke (see further below):

> "there's too much pressure, academic pressure.. but also in the community there's peer-to-peer pressure – if you child hasn't quite achieved the grades

> they wanted or if the school says 'actually your child can't stay on here in the sixth form' then people do feel shamed.. the schools aren't going to keep them on unless they're going to achieve those grades because of league tables and our kids are only really in either Jewish schools or private schools so that's pressure… and the young people that don't then make those grades don't really know where to go or what to do"

Whilst the interviewee also indicated that parents may be reluctant to accept that a child was struggling or unwell, once this had been acknowledged, they also indicated that seeking support could prove difficult. In particular, they reflected on the fact that the cost of accessing services could be problematic for some families. However given high thresholds and long waiting lists for statutory services, the 'private route' was often the one taken by families when a child or young person was in need of mental health or wellbeing support. The interviewee also noted that their organisation:

> "has highlighted the need for increased capacity via CAMHS to a number of local authority colleagues for the past decade. It is evident there are a number of initiatives on offer to support young people's mental health. There is a need for a strategic response and ultimately a need to support those with low level anxiety etc who do not meet the current thresholds to access the support they need. There has been an increase in the number of young people accessing private therapists (mainly recommended by word of mouth)"

In particular, they indicated that colleagues and parents who contacted them frequently expressed concern that CAMHS services across the country were often operating such very high thresholds such that unless a CYP was clearly articulating that they were suicidal they were either offered no therapeutic support, or perhaps three or four sessions of seeing a psychologist. Accordingly the interviewee is increasingly having to signpost colleagues towards recommending private therapy, a situation which they saw as problematic as it then placed a burden on youth workers who are not trained in such areas to "work out if somebody is the right kind of therapist for that child". They further flagged up the intrinsic link between safeguarding and mental health, referring to the important position paper issued by Reshet in 2018[41] on safeguarding which reflects a number of concerns common to those identified within this report (i.e. online social media; family violence etc.).

Importantly, and in common with other interviews undertaken with professionals (education, community organisations) and the young man interviewed (below), this respondent argued that 'parachuting in' specialists into Jewish schools is not the best or most appropriate way of ensuring that young people are aware of mental health and well-being danger signals and available services, as these 'in-reach' sessions typically deal with a range of issues such as sex, drugs, alcohol etc. which are relevant to mental health concerns but the trainer is then:

[41] https://reshetnet.com/wp-content/uploads/2018/02/Safeguarding-position-paper-2018-e-version.pdf

> "parachuted out…the young person then has to go to science and it's like 'what the hell was that?''….I see it rocks young people, they don't know what to do with it… there's no processing time.. even if it's a shed-load of information, how would you then process it when the educator that you didn't even know was coming has gone, and then you're doing science, French whatever and then you go home. Can you talk to your parents [about it]? Can you not talk to your parents? And your parents ten to one shot didn't even know you were having that lesson"

Reflecting on the difficulties for parents to attend special events such as schools based mental health events if they are working, or if such family-oriented events occur in evenings and within limited time frames which are often taken up with supporting homework or a child's (or parents') social commitments etc., this interviewee also emphasised that many parents are experiencing anxiety about their child's academic and social performance. Specifically they noted that academic achievement and pressures to look elegant – including girls sometimes being encouraged by parents to have plastic surgery to correct an imagined fault in their appearance – were seen by some parents as equating to a young person's happiness. Moreover that there are often enormous gaps in parenting skills with women in particular wanting to be 'best friends' with their daughters, which can lead to a negation of basic boundary setting and a blurring of parenting roles:

> "I find that incredulous that actually that's what my generation think is a real positive…. They [CYP] can have lots of friends but they're only going to have one mum .. [hence the necessity of] setting boundaries which are very clear… but I also know that those parents are not going to go to any parenting course that the community would put on. Ever".

The respondent also highlighted that there is a critical need for 'informal educators' and relatively young, highly trained 'detached youth workers' who are not based in a specific building or agency, but are in locations where young Jewish people gather and where it is simply possible for CYP to have a conversation with a trained young person. Based on their own prior experience, they spoke about the importance of a trusted youth worker being able to

> "have conversations with the same young people every week… not in a building but 'how *are* you' [emphasis in interview and indicating therapeutic type conversation] but just 'how are you doing? What's going on? Is your mum still pissing you off? Those type of conversations because when you see young people on a continuum then you can process with them what is going on for them".

Whilst commending highly the work of informal educators and youth leaders working in synagogues and youth groups, or who are acting as Madrachim, this respondent pointed out that they are "worked to the bone… they're swamped and that there are a lot of kids they don't know". In common with reports from some young service users

(see further below) and parents, the interviewee also highlighted that it was often other young people who are the first to know about a peer's depression or suicide ideation, stressing how one of their own children phoned them for advice in a highly distressed state after a friend texted to revealed that they were planning on committing suicide.

The stigma associated with mental illness was also highlighted within this interview and the theme of the especial problems experienced by the strictly Orthodox - which has arisen repeatedly within this study - (articulated by young people, educators. Parents and specialist agencies working closely with strictly Orthodox communities) was again flagged up, with the work of organisations such as Noa Girls and the London Jewish Family Centre highlighted as being able to provide non-stigmatising, holistic, intensely private support to this sector of the community given that "the strictly Orthodox won't use certain services… unless it something extremely serious".

The interviewee also emphasised that there is a significant lack of knowledge across and within the entire Jewish community about the "huge amount of youth work" which is ongoing; particularly being undertaken within large, Reform synagogues. Importantly they also commented that there is often minimal knowledge of, or misunderstandings about, the services provided by agencies such Norwood or Jami.

The overarching recommendations from this respondent included the absolute necessity for the recruitment and use of younger youth and mental health support workers who were seen as accessible by young people. Youth workers are able to build up a relationship over time with a CYP, so that a young person who was beginning to struggle but who had not reached crisis point did not have to risk seeking out specialist (typically stigmatised) help via GPs and then potentially be turned away as not unwell enough to warrant intervention if they were already in a supportive relationship with a trusted, trained individual who could provide signposting.

Thus for example having well trained youth workers engaged on an employed basis in synagogue "involved as part of each Bnei Mitzvah programme" or in school settings, or who were available to young people in a non-stigmatising, quasi-social setting (for example popular coffee shops) and who would then be able to sign-post or flag up support needs were seen as critical in engaging with young people before they reached crisis point.

Similarly it was highlighted that there must be far greater sharing of knowledge in relation to available community led services, closer working with statutory services, awareness of (and support for) the varying approaches and services required to reach different sectors of the community such as the strictly Orthodox; further work required with young people at university; and a strategy for engaging the community broadly around parenting skills and modelling healthy, supportive behaviours which strengthen young people's wellbeing.

7.2 Interviews with Young People – Service Users

In the interests of the highest levels of anonymity/very strict confidentiality guaranteed to all service user participants, within this section of the report, quotations or potentially identifying information is not attributed to any specific service user detailed in the table

above. In addition, certain information on their particular circumstances has been omitted/elided to avoid any potential for identification.

All three young women service users had accessed a specialist Jewish community organisation which provided a combination of a unique tailored, individualised support service (which included key workers who could act as a supportive bridge between the service user, parents, schools and statutory services as well as a limited amount of therapeutic support and drop-in facilities). The service is available for young women usually up until the age of 24 but with the possibility of an extension in case of severe need to 25 years. Typically it is accessed alongside statutory services. In addition one of the young women who was no longer eligible for standard CAMHS services as a result of turning 18 was awaiting access to the Tavistock Clinic, and a third respondent had also attended the Tavistock.

All three of the service users - who varied in degrees of religious observance and familial background and who had attended different schools - spoke about the intense pressures within the Jewish community to keep up appearances of normality and high achievement/adherence to community norms - both academically and in terms of normative family presentation.

> "that's the only option: be a doctor or marry a doctor, or maybe a lawyer"

> "there's so much stigma, when people know you have … they look at you as though you are a different person, you're not accepted into lots of different groups and then when you start official dating [arranging a shidduch] – if they find out something they will turn around and say 'no' so it cuts off a lot of things for you"

> "I felt really judged [by teachers as well as other pupils], because I felt like they all think I'm basically really messed up and crazy .. but there is so much going on [amongst peers] and people just aren't talking about it"

Thus it was felt remarkably challenging to publicly acknowledge that there were difficulties either at home (for example in relation to problematic inter-family relationships or parental mental health needs), or in relation to their own mental health and wellbeing. Inevitably these complexities made it exceptionally difficult for CYP to access support until they were near, or in, crisis, with the unspoken taboo on disclosure acting as a barrier to even having conversations with parents or potentially supportive members of the wider Jewish community in relation to their troubled emotions or practical difficulties at home. The fear of both stigma and also concerns over confidentiality given the close-knit nature of the Jewish community in the North West London heartlands featured within all three narratives. In each case the young women's difficulties manifested as eating disorders and it was not until they were quite severely unwell that they were able to access support.

> "My family were very unhappy that people in the community were finding out about the way they behaved behind closed doors"

> "Rabbis just shut it out.. in my mind they are just scared of it because it's like an unknown zone so let's not go there"

> "there was a school counsellor but it wasn't so… there wasn't so much help available.. I think the whole stigma of mental health was very prominent"

> "a lot of the more religious schools don't let people to come in to speak about mental health, like it's just not an issue, they don't offer mental health first aid, they don't offer any speakers to come and speak about it"

The issue of lack of both knowledge of where to turn for support and fears over the stigmatising impact of it being known that an individual was having problems combine to create an enormous hurdle to be overcome. This is particularly well illustrated in the case of one young woman who explained that her own depression, anxiety and eating disorders arose from exceptionally difficult family circumstances which included parental mental illness, poor parenting, disabled siblings and considerable resultant caring responsibilities placed upon her – all issues which reiterate findings from multiple interviews with service providers, rabbis and education specialists undertaken within the earlier Kofman and Greenfields 2017 study into safeguarding CYP in the Jewish community.

> "I can honestly say that I think I was depressed from under the age of ten because you have such a high-pressure environment and schools aren't necessarily equipped as well as well as they should be to deal with this kind of thing. My school definitely wasn't. They sort of picked up on little things, but nothing was ever done so I developed depression, [then] when I was about 13 I developed anorexia, followed shortly by bulimia and then my depression got worse and I became very suicidal".

From the age of 14 this young woman was in contact with CAMHS, having had to persist struggle against parental refusal to allow her to obtain support, and also an inability to access support in-school

> "Several times I tried to speak out about the fact that I was struggling with my eating and also a bit of self-harm. My parents were very unhappy for me to speak to someone but in the end they gave in"

Confirming the point raised by several interviewees including the youth specialist above, this young woman only had a handful of appointments with the CAMHS eating disorder specialist. On discharge and when seeking to see her GP about her self-harming, she felt that she was repeatedly silenced and disregarded as her parents were always present during medical appointments and sought to manage the information being shared.

It was not until she 'cracked' in the sixth form and it became very self-evident that she was both struggling in school and staying away from home and living at friend's houses that her school initiated safeguarding proceedings. From that time onwards she received a foster care placement and then via a (non-Jewish) GP was referred to CAMHS where she had therapy for depression and associated issues before being discharged and referred to the Tavistock clinic prior to the age of 18.

Although she praised CAMHS and the Tavistock Clinic she stressed that there is a high level of discontinuity with numerous staff changes and a sense that

> "CAMHS really was preparing for the ejection of me long before it happened… I was just jumping between people, a little bit of people who could offer different times, people would be leaving or running late or [cancelled] because doing something different that day… I think it's so important to have that stability and continuity and consistency… you need that"

This service user was fortunate in that at the point her life had become so challenging that she was no longer able to live at home, as part of the package of support she received she was referred by her school to a highly praised specialist Jewish agency who were able to offer a wrap-around service and liaise on her behalf with her family, school and also the Tavistock Clinic:

> "there's only so much organising a 17 year old can do, and I was so distracted by so many other things that it was really important to have someone there who was writing letters, emailing, calling up, asking are they going to arrange appointments, do they remember that I exist, sort of thing…"

Although it was following the school safeguarding intervention that she was referred to the support service for young women who have since provided ongoing provision - whilst she completed her education and thereafter - this interviewee was critical of the fact that until her situation was self-evidently a safeguarding concern and she had left home, she felt that the intense nature of the Jewish community and school systems precluded her accessing support. Of great concern she stressed that worries over confidentiality issues had existed during her time in school, as the school counsellor was seen as a:

> "friend of the head teacher, of the staff [and knew her parents] and that it was never a confidential secure place that you could go to and feel safe and talk about how things are. You are simply made to feel that you don't actually have a problem which is a running theme with a lot of people offering counselling services [within the Jewish establishment]"

Indeed the way in which schools (and all of these interviewees had attended Jewish schools) dealt with mental health worries was seen as problematic, although it should be emphasised that in each case the young women (aged from 18 to 24) were reflecting back on prior experiences and indicated that at least in the case of more mainstream Jewish schools circumstances may have improved in the time since they had left. Indeed one young woman indicated that the support agency she accessed is now working very closely with her former school to engage staff and pupils on early interventions and information sharing; whilst another stressed that she understands that there is more openness in relation to discussion in school and synagogues about wellbeing even in the last couple of years.

> "I have to say my school handled it appalling. The lack of sensitivity. The lack of confidentiality [how the school dealt with her situation]"

One interviewee spoke about being de facto expelled as her school indicated that they felt unable to support her mental health needs (a theme which also emerged in some parental interviews), whilst another indicated that "they kind of tried to .. shut it out..

[stating that] we'll try to raise awareness but only to a point because people are doing it for attention"

Despite the fact that they acknowledged the beginning of greater awareness of mental health within the community, all three interviewees emphasised the critical need for broader discussions across the community about mental health, and in particular in relation to raising teachers' awareness of both mental health fluctuations and that academic pressures can prove devastating to pupil stability, as well as the necessity of engaging with concerns over confidentiality. (See further recommendations below)

Indeed two respondents emphasised how important it had been that they had received an opportunity to (at least initially) discuss their mental health and wellbeing needs with someone who was outside of the 'Jewish Bubble' and who was thus perceived of as more likely to listen to them, rather than downplay their concerns.

The young woman who explained that she had to leave home before she could access support stressed that it was only when she was able to make an appointment with a non-Jewish GP who did not expect her parents to be present and monitoring conversations during her appointment, that she felt able to be heard.

Another interviewee also emphasised that CAMHS staff or private therapists speaking to parents or teachers can also provide an erroneous impression of how well a young person is managing:

> "you know it's important sometimes – it might be better to speak to the child before you speak to the parents. They might not want you to go behind their back and for them [CYP] to be understood like, they obviously haven't approached their parents for a reason"

This tension between use of Jewish services and non-Jewish services emerged on several occasions within all interviews.

> "CAMHS, they just didn't have a very good understanding of the culture and I know I can remember very clearly when I talked about my school.. how people were talking to me, how my school approaches mental health my psychologist's reaction has been shock.. my school was.. in the beginning they were warm - but when you're not suddenly spouting A*s and being a top student … they can't understand that mental health is something can have up's and downs.. one day you're fine and then next day your having a full blown panic attack.. so yes CAMHS were understanding but they're only understanding up to a point"

> "I was using CAMHS .. I went there when I was 15 and then I was in a Jewish Orthodox boarding school from the age of 16-18 where CAMHS still saw me.. usually they say goodbye to you when you're 18 but they extended me for a few months longer and as I need further help my therapist (in CAMHS) said that she'd heard about this Jewish organisation .. instead of waiting to be referred to a non-Jewish team that would take a few months.. but I was quite happy as it's nice to have a service that understands you in terms of my culture and stuff"

> "CAMHS definitely helped me, they gave me tools and everything but it was just hard to explain certain things.. difficult, even my festivals and things like that..

> difficult to connect to someone that's not experienced it and a whole week of festivals and meals and food"
>
> "So I was in school I wasn't having any help and I started like going really extreme really quickly and the headmistress called my mum and said … what shall we do about this and my mum said basically we'll try a Jewish therapist but I didn't like her at all because… I just wanted to get out and see what it means not have someone Jewish who knows everything, just to have someone 'different'… I just felt like I wanted to be away – and not Jewish therapy, something like CAMHS"

Interestingly despite in two cases interviewees explicitly wanting to access non-Jewish therapists initially, and the third stating that "I don't think it mattered… but then maybe I'm more out of the box, more modern than some people", all responded extremely positively to being referred to the specialist Jewish agency. All repeatedly emphasised that the wrap-around support service, access to a key worker who could frequently be available out of office hours - often fulfilling a role similar to that of a detached youth worker as proposed by the agency interviewee above - and having someone who would liaise with services and family on their behalf or provide non-judgmental assistance in applying for university or non-professional employment, was hugely important in their recovery and stabilisation. This was particularly so, when offered in tandem with therapeutic services which albeit potentially provided to a limited extent in-house were far more commonly accessed via CAMHS or the Tavistock clinic.

> "[Benefits of referral to the Jewish service] it was a mixture of both - getting help fast and also being part of a Jewish service which meant that they could understand my anxieties and the stress of living with mental health issues in the Jewish community"

The third interviewee was in fact directly able to access support for her severe eating disorder *only* following contact with the specialist agency to which she had been referred by her school following an intervention by a close friend who approached the school counsellor and indicated how worried she was about the young woman. Prior to that "it was getting kind of worse and we didn't know what to do – a bit in denial, a lot in denial" but once she was put in contact with the agency "it is quite small, it is very very private, less people know about it" staff at the service were able to rapidly and directly intervene with her parents, and also her GP who swiftly arranged for her to be seen by CAMHS, initially as an outpatient and then within the inpatient service for a lengthy period of time. The wrap-around service further ensured that a key worker from the service also participated on weekly ward-rounds "helping me through the process of just feeling better about myself… because I was very ill, very very underweight"

In each case the respondents had been in crisis when referred to CAMHS leading to relatively rapid access to statutory services, with one young woman stating that "I was very fortunate that I was so unwell – you know it doesn't sound right but at the end of the day I only got help because of how unwell I was"

Another said:

> "nowadays.. they only refer you if you're at the worst weight possible, but that doesn't mean you're not still suffering with an eating disorder it just means you aren't at the criteria of the lowest weight possible and I think something really needs to change in that area"

As noted above, although the young people were generally positive about their experience with eating disorder services in particular, there were concerns about lack of continuity and the sense of being hurried, as well as lack of privacy when accessing services – not only (as indicated by one person above) in relation to parental attendance at sessions, but also:

> "I found it hard – confidentiality wise for example .. everyone is there and your therapist is like 'hi', says your name and clearly what you are there for .. also I knew people there.. it was horrible, I used to try and hide outside and slip in at the end… in a tiny waiting room – when the eating disorder service moved it was to a larger waiting room but you still see everyone.. when they take you out your mum and dad are there, everyone is there and they will finish off and go outside but then they [therapist] will talk things through in the corridor and it just feels like it's in the open. Obviously they want mental health to be out in the open more…but…."

All three young women repeatedly emphasised that despite that despite the secrecy around mental health issues, they were aware of the high level of prevalence of mental illness and well-being issues within their community and amongst their peers. The interviewee who had attended a strictly Orthodox seminary highlighted the particular problematic faced by members of her community given that "people are not supposed to use the internet", leading to a complete lack of knowledge about where to turn for help or indeed what are common experiences or emotions or indicate an abusive situation which requires safeguarding – a theme which was also considered within the education specialists' focus group:

> "Me and most of my friends we grew up not being given a sex education at all, not being allowed to use the computer, rarely, internet was a no- no… many girls in my school and my society they don't even know what sex is until they are 18 and then they get married and they are taught about it, they don't even know why it's not safe to go out on the street [alone at night].. so many things have happened to girls and they don't know when to let it stop, there's no sex education, no awareness of the internet….they are very scared you know 'oh gosh the internet is the worst thing'. For example there's a very Orthodox lady works with me and she has a child and she believes her child has got mental health issues but [it is represented as] the school is just making it a problem.. but you can't just stop talking about these things.. .running away"

Another young woman who had recently left school spoke about "a craze for self-harming" whilst the third indicated that their former school is:

> "overloaded.. drug abuse, self-harm, suicidal problems … [pupils] literally at the end of their tether, not wanting to be in lessons, not wanting to be in school, not wanting to be part of their family".

On being asked for recommendations for assisting young people to access services and enhancing mental health and wellbeing amongst their peers (reflecting upon their own experiences and what they would have wished to have known when they first became unwell), there was unanimity amongst all these interviewees that there is a critical need for greater awareness raising, education across the community (including rabbis, education staff, young people and parents) and supportive, wrap-around, non-judgmental services for CYP which can be accessed before a state of crisis is reached.

Amongst these respondents the level of awareness of Jewish mental health and wellbeing services such as Norwood and Jami was absolutely minimal, and indeed because of the extreme discretion associated with the specialist agency which they themselves had accessed, only one had known vaguely of its existence (because it had been used by school friends and peers) prior to referral to the organisation. All three highly commended the agency as a model of good practice which was sensitive to individual needs but also seen perhaps as "being a bit religious for some people which might be off-putting although… they cater to all sorts of girls, mainstream Orthodox, strictly Orthodox but there are quite a lot of religious people work [there]"

Norwood was seen only as offering "social work" or "family support I think but I was never offered any support… some of my other [disabled] siblings" or for those with "special needs" whilst Jami was regarded as "being for older people"; "having a stigma associated with it....it's for full blown schizophrenia or something" "being for people who are barely religious.. it's nice having groups or chats [at Jami] but strictly Orthodox girls would never do that [because seen as] they've got a lot of crazy people coming there" or in one case "I don't know anything much about them".

One respondent referred to support being available through JWA but noted that:

> "a lot of the girls.. it's hard to pick up on the real benefits these services can offer – it is seen as appealing more if you're being beaten by your husband so for younger girls they definitely wouldn't have clicked that maybe Jewish Women's Aid can help them but if you're in the sixth form and struggling and a bit less religious I'd refer somebody to JWA but otherwise I'd recommend them to go to Noa"

It was therefore clear that young service users felt that there is a critical need to increase awareness of available services and service offers:

> "it would need to be publicised through schools – 100% because I only know about JWA because of my school but I didn't know about anything else and then I picked up on a couple of other places [through word of mouth]..…"

> "people won't even date somebody because in the past they had anxiety – that's how bad the stigma .. so more education.. evenings where people can go and discuss their concerns, as well as learn about these different things. Jewish

people have very specific ideas of what different diseases are, so if you don't fit into that category they don't understand"

Another interviewee suggested that, replicating the JWA awareness raising model, it would be possible to put up posters and information leaflets about mental health services in schools and community settings which indicated where and how a young people could access support which did not require a GP referral or to go through school processes. Drop in services and a phone-line were also seen as positive ways for CYP to seek advice and support:

> "a walk-in place on the main road… not necessarily about mental health [but offering a range of support and advice] that you can walk in – where it's a Jewish place with Jewish people working in it. There's one in Finchley like on mental health but you never see a Jew walk in there so somewhere like that where you just walk in and talk about it and it's open" [42]

In addition to the concept of a walk-in facility comprising access to various sources of information, young people were enthusiastic about the idea of a youth oriented drop-in service accompanied by a telephone help-line:

> "perhaps for kids from 12 upwards, to maybe 25 [facing] abuse at home"

> "A drop-in centre ..and a phone line that everyone knows about - because they have Childline – a few times I called it and there is someone there and you can express your opinions and I didn't know where they were they could have been in America for all I knew - but if you feel like you need more help they can say to you 'look there's a number you can access'

> "a sort of Samaritans for Jewish people"

All of these respondents felt that if a phone line dedicated to supporting young people was implemented, it should be possible for a caller to request either a male or female worker, given that the young person might be speaking about deeply personal issues or as a result of their upbringing feel uncomfortable talking to someone of the opposite gender (particularly for example if this related to sexuality or sexual orientation).

A further stream of requests related to the need for "more therapists" attached to agencies who could support young people who were currently outside of the CAMHS

[42] Importantly this proposal mirrors to some extent that made by a community worker who was leading on mental health and family wellbeing within another agency which worked with the more Orthodox element of the community. This staff member emphasised that the stigma in acknowledging mental health or family difficulties meant that there was a real fear of accessing services in a situation where individuals might be recognised. Indeed the mental health and family support offered by this agency took place within the same building as benefits advice and associated services, meaning that workers were approached discreetly by parents in need who would not otherwise seek support. As such they recommended the need for a drop-in centre where family support, parenting advice and mental health services could be accessed in a highly discreet manner where nobody would be aware of the reasons why an individual was entering the building: "If the [community/JLC] had money and actually bought a building and rented it [at a relatively cheap rent to diverse agencies working with the more Orthodox community] - we have a strategy of parents coming in here on a weekday and on a Sunday and accessing our services in this kind of ...holistic manner"

service and who might either be waiting for a long time for services or who were not seen as severely ill enough to warrant referral to adult services:

> "I don't know how other people get on with it but I've [waited already] for three months to get into Tavistock or wherever I'm going to go to [following discharge from CAMHS]… not having to wait around until it gets worse and worse"

Whilst as noted above, there was appreciation of the fact that non-Jewish services (or non-Jewish therapists and counsellors who were located outside of intensely close-knit community structures) could have a clear place in supporting young people. Given the immense warmth with which all spoke about both their Jewish identity and the services they received from the Jewish agency that they had accessed, it appears that the mode of holistic service delivery (such as the one outlined above) emanating from within the community would be particularly appreciated and should be both supported by the community and more widely publicised.

Interestingly, one young woman (who had left home at a very young age as a result of family tensions) stressed that there was a need for some form of residential 'community house' as:

> "there is a real, real need for that.. something about having somewhere to go and getting out of a toxic environment at a young age, where you can actually reach your potential. But at the same time having thought about it a lot, it's a very difficult situation to master. Because where do you draw the line? Are they allowed to smoke? Are they allowed to drink? Can you allow men into the equation? Who looks after the girls? That sort of thing.. there is definitely something to opening up a girl's home. That would be fantastic"[43]

As outlined in the literature review the success of the Soteria House model utilised in Israel[44] suggests that this could indeed be a feasible option to provide supportive and therapeutic facilities for young people nearing crisis, but who are not yet so unwell or traumatised that it is unlikely that they will be able to experience positive wellbeing and recovery/social integration without very long-term interventions and support.

Given the discussions outlined above and in other interviews (particularly the focus group with education specialists) in relation to the intense pressures within the community to be academically 'successful', young people also highlighted the need

[43] A similar proposal was also made by a Headteacher who noted that: "I've always had this idea that maybe the community could also benefit from a house – quite a big house – that is run by a couple if you like, that looks after kids who for a finite amount of time cannot be at home. .. sometimes you have kids who, they're never going to be fostered, and they've got to move out of home and it's impossible to find families for them. Or just there's a bit of a breakdown of relations. And [the home would be] seen as there's somewhere that the kids could be helped"

[44] https://www.jpost.com/HEALTH-SCIENCE/Jerusalem-mental-health-home-modeled-after-the-Prince-and-the-Turkey-504046 . The proposal for community run intermediate 'homes' would also address the need for support for young adults who have experienced family breakdown and/or who are perhaps seeking to move away from their sector of the community/family circumstances but who are lacking in support networks, resources, mainstream education or financial support and life-skills, a theme noted by other agencies who responded to the survey for example projects which provide support for LGBT+ youth or working with young people who have expressed a desire to leave strictly Orthodox communities. See further (provision in Israel): http://jewishnews.timesofisrael.com/spotlight/when-life-begins-again/

for parents and schools to seek to identify and celebrate alternative models of achievement:

> "parents are pushing their children to excel in everything… but you know a builder, an electrician is also a profession but you see people wanting their kids to do medicine to do law, to do all the degrees which are really, really stressful through five or six years of university and that itself brings on pressures, brings on anxieties"

> "If you don't want to do it.. but if you're born into a family where obviously you're going to be a doctor because your dad was, your grandad was…[there are excessive pressures placed on young people]."

Accordingly, it would appear that there is a general consensus over the need to seek alternative education routes (and educate the wider community in the value of this), so that less academically able children or those who wish to step outside of community norms are not subject to undue pressures or stigmatised as failing to achieve.[45]

Finally – all three young women interviewed stressed (in common with the youth specialist whose interview is detailed above and educationalists) the importance of having younger, accessible counsellors, advisors, therapists and youth workers who were perceived of as being aware of the challenges and pressures they face in the modern world:

> "it's hard – when you are in hospital like your doctor is your doctor you can't choose someone younger but if they're maybe 30 you feel more relatable to them than if they 60.. but with things like phone-lines and stuff, people going into schools it would make a difference to be younger.. or even people that you know [have experienced mental health difficulties]"

> "younger people but teaching and awareness [for] the people who go to work with high school kids – not just allowing it to be people who came in at age 19 to teach me when I'm 15. And they have no real clue about mental health and they're absolutely petrified, as closed up as I am, and it scares them"

> "well somebody who isn't 70…."

Finally it is worth noting the observable impact of the fact that face-to-face interviews with service users were co-convened/led with a female psychology student research assistant in her 20s and this fact – and that hence young people felt that they were able to clearly articulate their experiences and needs to someone who was of a similar

[45] This particular theme of the need for respected non-academic A levels/6th form/degree alternatives has in fact also been identified by the Department of Education who in 2013 announced a new TechBacc aimed at enhancing the status of non-academic qualifications: http://www.bbc.co.uk/news/education-22225953 and the launch of a tranche of new apprenticeships in 2017-18 which enable students to qualify in professions and trades whilst gaining degree level qualifications 'on the job': https://www.theguardian.com/education/2018/mar/06/new-style-apprenticeships-all-the-education-none-of-the-debt

age and who entered into dialogue about experiences and needs - was commented upon positively by all three interviewees who noted that:

> "it's been lovely to chat to you guys – you've been totally different to the guys I've had to deal with in their past.."
>
> "thank you so much.. [this conversation] is making me rethink my occupation.. I do have a big passion for mental health now that that I've gone through it but I never thought it could even be an option but now… trying to end the stigma like in the Jewish community"
>
> "this is really helpful".

7.3 Interviews with Youth Workers/Madrichim

In this section of the chapter, findings from the two telephone interviews (conducted by the research assistant who is broadly of a similar age to interviewees) are presented, resulting (on audio/transcription of discussions) in a noticeably more informal style of response/use of language than when an older team member was present - as during the face-to-face interviews with service users. The youth worker respondents were offered a face-to-face; Skype or telephone interview and both opted for telephone contact which may again be indicative of more general preferences amongst young people for mode of engagement with youth support services, at least during the initial contact phase, a theme borne out by the eagerness of some young service users for an accessible phone line service[46].

Neither of the two youth workers identified as having experienced direct mental health concerns themselves, and as such these interviews were of relatively short duration and focused on their perceptions of mental health needs within the community, the type of issues they encountered amongst their peers and young people with whom they work, and recommendations for service delivery and training. The only male we were able to interview for this section of the study was a youth leader and we suggest that this difficulty in accessing young men is indicative of the reluctance of young men to speak about mental health problems although this interviewee acknowledged than many of his (male) peers experienced wellbeing difficulties – particularly in university settings.

Both of these young people are actively involved in youth work through their synagogues and have received training from central agencies in relation to supporting young people. Their roles do not focus explicitly or exclusively on mental health and wellbeing, although inevitably they encounter CYP in diverse settings who are suffering from stress and anxiety or other wellbeing (or occasionally safeguarding) issues.

> "Thankfully nothing too serious: stress, anxiety of being away on a two week camp. Managing it and making sure they are ok. On camp there is a structure

[46] Nb: two service users indicated that they felt accessing support via on-line chat systems might prove both problematic for people from communities where internet access if difficult/frowned upon, and/or can be seen as more distant and daunting to access.

> to refer to the youth director or their deputy as soon as we're aware. Everything is written down then passed over to the youth Director. Then they deal with it…"

However it was also noted that based on conversations they had had subsequently, "it seems that there is poor follow-up after camp finishes".

The young woman noted that in her opinion "there is an increase in mental health needs, not just in the Jewish community but also in general" stating in particular that the most common issues she is aware of (both amongst young people she works with and her peer group) are anxiety, depression and eating disorders.

This respondent reported that "almost all her friends have been involved in mental health services at some time – NHS but mostly private therapists". She was not aware via her working context of how young people who are experiencing wellbeing or mental health problems seek referrals or access services. Predominantly in her experience young people access mental health support through "word of mouth through family and friends" or via school counsellors and networks if they are of school age. For young people aged over 18 or in universities they typically self-refer although as a result of preferences for rapid access to private therapists they typically "find private therapists from within the Jewish community". She stated that amongst her peers cultural awareness is seen as important in a therapist, and that "there are a lot of internal networks between young people and parents who refer each other to private therapy" (a theme which was also emphasised within the education focus group).

Amongst her peer group:

> "a lot of friends in university have tried to access services but due to the waiting lists go their GP for a prescription [for anti-depressants] instead"

or attempt to find a private therapist via their community networks.

Similarly the young man indicated that he and his peers at university felt that there was a critical need for universities to respond more and raise "awareness of suicide in the student population" noting particularly the stigma around acknowledging mental health difficulties for young men. He indicated however that

> "there's a lot more awareness in unis versus schools but mainly because the university's mental health provision is shocking[ly bad]. There's awareness but not provision to help[47]"

[47] It is worth highlighting here – as mentioned in the literature review that there are significant concerns around student mental health; whilst (see Chapter 5) university Chaplaincies and JSocs typically rely on university counselling services when Jewish students contact Rabbis or student support officers to disclose mental health problems. Recently (May 2018) the Vice Chancellor of Bristol University - which has a very large Jewish student population – has issued an open letter which reflects upon the high number of student suicides at the institution, specifying new service provision which is being put in place http://www.bristol.ac.uk/news/2018/may/open-letter-from-vc.html . Despite this attempt to engage more fully with students in relation to mental health and wellbeing, in late May 2018 there have been student protests at Bristol University https://www.theguardian.com/education/2018/may/26/bristol-university-faces-growing-anger-after-student-suicides with students marching to angrily demand additional support is put in place given the shockingly high number of deaths of young people within a few months.

In relation to help-seeking behaviours for mental health, both young people indicated that therapists having cultural awareness could be helpful but "that you might not get in the NHS" with one respondent reflecting on the fact that given the stresses under which the NHS is labouring

> "their mental health funding is awful.. it's important that the resource exists because people need help. In an ideal world it wouldn't need to come from the community but as it stands – it's good that it exists"

Despite this awareness of the potential for delivery of provision by Jewish agencies, both interviewees had extremely limited knowledge of what precisely was available from Jewish run services to support CYP in need.

The female youth worker noted that was unaware of anyone she knew who had utilised specifically Jewish service providers, noting that "she had some awareness" of Jami but the service and other community provided agencies were often not seen as "accessible or easy to approach". In particular she emphasised – a theme which has been identified elsewhere in this chapter - that the lack of regular ongoing contact with specialist Jewish agencies means that there is limited awareness of what is available and

> "no access points.. that's it not made clear to young people how to access services".

She felt that whilst CYP might have vaguely heard of Jami and Norwood as a result of information sessions at school "when they are in someone's awareness it is only for one session - then they are gone… there's no [ongoing] community engagement". This parachuting in of service providers to discuss available services continued within youth groups and synagogues (and in relation to training offered to Madrichim) so services were known simply to:

> "provide a session then that is it – no follow up. A training day but no relationship there to continue the discussions"

This theme was also prominent in the interview with the young man who highlighted what he and his friends called 'free pen days' in school "probably between Years 7-9" during which information about external services were often "poorly delivered" as

> "it was a parachute" [individuals came in for a session in school as highlighted in the discussion with the youth worker] but nothing stuck…. Couldn't remember who was there".

The young man also indicated that he and his friends had almost no knowledge or awareness of services provided by agencies such as Jami and Norwood:

> "I don't know anything about them at all. The awareness [of Jami] was only because of a conversation about this study with a friend when they asked if

All of which – if taken as a snapshot of university provision across the country at 'Jewniversities' suggests that there is a critical need to explore the experiences and needs of young people away from home to see what provision can be offered from within the community in relation to mental health support.

there is any provision for Jewish mental health services we googled it and they found Jami – and that's it."

He also stressed that specialist services which work with Jewish youth agencies need to ensure that training isn't simply a one-off session or in the alternative simply offered to senior, older staff who are then required to provide information to youth workers. Instead he recommended that front line agencies:

> "engage better with youth movements to help with understanding and provide follow-up; offer training. You need trained professionals, rather than someone with a Psych[ology] degree who has a passion for it [MH]. Someone there to help us with follow up and to assist, give training to youth workers as well as higher-ups so that it trickles down".

Both madrichim emphasised the critical need for greater mental health awareness in schools and universities and also for youth workers which needs to be delivered by

> "younger people"
>
> "Younger people are better. From personal experience kids feel more of a connections with younger people who are closer in age and especially on camp or on tour the relationship between the counsellor and the kid is unique. They trust the counsellors after a few days and will discuss things they wouldn't talk to 'adults' about".

Accordingly the nature of the accessibility of youth leaders – as was also emphasised by the youth service lead whose interview was summarised above – creates particular opportunities for engagement with young people experiencing difficulties but (as highlighted within the education focus group) the knowledge available to madrichim is often relatively poor with a hierarchy of information in existence which frequently isn't disseminated to the person working on the front line and who should be alert to concerns about an individual child in their care.

> "Right now it's top down. An org[anisation] head with will speak to another head without speaking to the young people. There needs to be a bottom up approach. A lot of pressure is placed on communal rabbis to hold the role of 'who to speak to' and it doesn't seem like the right place for that to reside. For instance someone in a youth worker role should be involved in the process but [in the interviewee's experience] it's not touched upon"

It was also noted by the other interviewee that they were concerned that in relation to supporting a young person in community activities:

> "they don't feel [they are] given any information about welfare [concerns].. although interacts with them [the CYP] the most [they] are not included in discussions"

Both respondents felt that there was a clear need for more structured information sharing and awareness cascaded down throughout the entire Jewish community. In reflecting back on their own (fairly recent) school experienced both emphasised that they felt schools needed to engage in more depth working with young people

experiencing mental health needs and adopt a range of strategies which were outside of more traditional hierarchical approaches and models. Thus one person noted that:

> "within the school system there was a school counsellor and that was it… they've tried to put more focus on mental health and pastoral care due to multiple eating disorders but no change in structure – still have a school counsellor"

While the other interviewee indicated that

> "there was a pastoral manager and team but at school but they didn't have a good reputation because the teacher who was in charge of it was also in charge of behavioural issues – 'bollocking kids' so people didn't feel comfortable going there as the perception was that they're not very nice, they're intimidating"

On being asked to reflect upon whether it might be helpful to have a phone line or dedicated drop in service for Jewish young people, neither interviewee – who were not members of traditionally Orthodox communities and whose responses may therefore reflect a greater willingness to engage with more secular/non-Jewish services than would some sectors of the community, were uncertain whether members of their own communities (Masorti and Reform) would use such a service

> "kids wouldn't necessarily want someone culturally specific.. cultures can vary so much between different denominations so there isn't [necessarily] such a strong connection [to use of Jewish services] due to different experiences"

In conclusion – the responses of all five young people indicate that whilst having access to a Jewish service could provide comfort, cultural awareness and support, this was often less important than a young person being able to access appropriate support rapidly. All agreed that there was a clear need for greater education and communication across the community in relation to mental health needs and that moreover there was a clear lacuna in provision in schools with provision often poor or not easily accessible. Service users who themselves had experience of help-seeking emphasised the barriers to accessing support which were inextricably linked to stigma and confidentiality concerns as well as the tight-knit nature of the community which could make it difficult to be heard. Both madrichim emphasised that in their roles they required both better and more training, as well as being able to be parties to discussions around provision of support or concerns about young people in their care. The inherently (and perhaps inevitable) hierarchical nature of many youth and community groups means that Rabbis or other senior people who were not in close contact with CYP were the people who took decisions which were often not fully communicated to those on the front-line.

In common with other interviewees all respondents highlighted the issues around transition from CAMHS to adult services and the delays which could occur, as well as threshold issues which could – in the worst case – lead to suicide for some university students or pupils who were unable to access support.

It was also clear from the two final interviews with youth leaders that there is an enormous gap in provision at university level when young people are likely to be

particularly vulnerable. Given the extremely limited work within this study in relation to university students it would appear necessary to explore further how the community can support young people in higher education who are often away from home and their support networks, placing them at particular risk (including of suicide) when they experience mental illness.

7.4 Recommendations

Given the range of interviews included in this chapter recommendations from each category of respondent are presented separately:

Recommendations: Youth Coordinator

- Create a 'one stop shop' where all mental health support initiatives are monitored, assessed and subject to evaluation and feedback in order to ascertain that support provided to young people in the community are of a uniformly high standard.
- Engage detached youth workers in schools and community settings. Not only does this place less pressure on teachers to deliver mental health services and signpost to services, but also offers routes to support which do not require approaching teachers or school counsellors (a theme expanded upon by Madrichim).
- Ensure that Bnei Mitzvah age children are taught about mental health and wellbeing.
- Offer parenting courses as part of the ‘points system’ for parents who wish to enter their children into Jewish schools. Parenting classes (and other sessions pertaining to wellbeing) to be offered at accessible times for parents who are working. Adequate notice given so that busy working parents or those with other commitments are able to attend classes on parenting, mental health and wellbeing events.
- Increased safeguarding training required across the community to understand the linkages between abuse and mental health as well as how to support young people appropriately.
- The need for a holistic focus on young people's mental health to be shared through agreed appropriate structures between statutory and non-statutory sectors.

Recommendations: Young Service Users

- There is a fundamental and critically important need for greater awareness raising and education across the community (including rabbis, education staff, young people and parents) on mental health issues and available services.

- There must be a concerted effort to break down the stigma associated with mental illness at all stages, and within all sectors, of the community

- There is a need for a recognition of the damage caused by highly competitive and overly-academic hothousing which does not recognise or support the fact that alternative educational pathways or life-choices (including in relation to sexual orientation or not wishing to marry young or train for a profession) are valid, and can be a cause for celebration for a young person.

- That there is an important need to ensure confidentiality for young people such that parental voices or those of educationalists and powerful community members do not silence their narratives, or the requests for help of young people in need, who are in 'the Jewish bubble'.

- There should be delivery of supportive, wrap-around, holistic, medium to long-term, non-judgmental services for CYP which can be accessed before a state of crisis is reached and which offer support with engaging with families, statutory services and schools; as well as having the potential to offer unbiased tailored assistance in applying for work or higher education.

- There is a need for accessible younger counsellors and support staff – including those working as 'mentors' or 'youth workers' - who are perceived of as having a greater awareness of the pressures facing young Jewish people than do many parents, education specialists and community leaders such as Rabbis.

- It would be helpful for some young people to be able to live in a supportive family type therapeutic environment which enables Jewish identity to be retained and supported when a young person cannot remain at home. Potentially the community could fund and support such initiatives which may draw upon successful models of service delivery in use in Israel.

- The wide-spread stigma of engaging with mental health services and need for privacy for many service users and their families should be born in mind - particularly so for some sectors of the community. As such, access to services within a context where other advice and information or family activities are provided would enable support to be obtained in a discreet or opportunistic manner (perhaps delivered through the provision of premises owned or leased by communal organisations which could then rent out premises to a range of organisations)

- In addition to wider discussions on mental health and accessibility of advice through a variety of settings (such as schools, synagogues or through existing services), there is need to consider the delivery of phone lines for (and staffed by suitable trained younger people) CYP, and drop-in centres. Information on such new and existing services should be widely disseminated. For example, through posters in community and school settings.

In addition, although not directly proposed by young people it is clear that there is a need to ensure that the gap in provision for young people who are not in school or who have been moved on from CAMHS and are not in adult services are filled, potentially through the development of tailored (and well publicised) activities and therapeutic services delivered by existing agencies such as Jami, Norwood and Noa Girls. The lack of provision for young men in the Orthodox community in particular was flagged up given that the highly acclaimed Noa Girls service caters only for young women. Work is needed to shift perspectives in relation to the services delivered by Norwood and Jami which are seen as only for people with 'special needs' or 'older people' or those who are 'really crazy'.

Recommendations: Madrichim/Youth Workers

- That there is access to more and better training for youth workers in relation to mental health. In particular that this does not involve simply 'parachuting in' specialists to deliver an information session or the expectation that a more senior community figure will 'trickle down' their own learning.

- There is a need for younger people who are well trained and able to deliver targeted mental health and well being support for CYP using communal services.

- The need for ongoing dialogue and engagement with senior staff and Rabbinic figures is important, as at present madrichim feel that they refer up in case of concern, but they are then typically unaware of follow up or children in need of support for whom they are caring and about whom particular alertness is required.

- There is a clear need for greater levels of information about available services delivered by, and for, the community given the almost non-existent knowledge of organisations such as Jami and Norwood

- Reflections on school-based services were very similar to those articulated by service users and hence mirror the above recommendations for flexible advice and support provided by younger people (and potentially not simply counsellors but also youth workers). These should take place in a variety of settings where a trusted, longer-term relationship can be developed, rather than having 'free pen days' when an agency provides a short session on their service offer and then leaves without the young person feeling adequately equipped to seek follow-up support.

- For young people in university there is a critical need for accessible appropriate mental health support (which may potentially include distinct Jewish elements so that cultural competency is ensured, although this was not seen as crucial).

The lacuna in service provision and long delays in accessing support for university students were noted as being of great concern

- There is a crucial need for greater awareness of suicide risk within the community – particularly in relation to young men who face especial difficulties in acknowledging that they are struggling with mental health issues.

Chapter 8 – Conclusion and Recommendations

In this concluding section of the report we highlight what appear to us to be the overarching themes and priorities of the research, and provide a number of key recommendations. These broad-brush proposals must be read in conjunction with the more granular level recommendations provided at the end of the findings chapters which deal with responses from Education Professionals, Parents and Young People.

As can be seen throughout this report – most noticeably when reviewing the comparative findings pertaining to identification of key issues by all main groups of respondents (presented in Chapter 2 – Methodology) there is a considerable degree of agreement in relation to the main issues impacting the mental health and wellbeing of CYP.

In order of prevalence these pertain to concerns over the deeply worrying levels of anxiety and depression experienced by young people within the community. More specifically there is a broad consensus that anxieties in relation to school and university performances lie at the root of much ill-being (a finding rehearsed in the data gathered from schools, parents and young people) which also appears to be related to wide-spread pressure to achieve academically. Whilst this is found throughout society within an increasingly exam-driven culture, there would appear to be exceptional pressures within the Jewish community for young people to excel at education and then to enter into the professions. This emphasis on particular types of 'approved' life-choices and career paths can, as we clearly evidence, become toxic when focused upon to the exclusion of alternative, equally valuable routes.

The theme of young people with learning difficulties, autism or other learning difficulties (which as we suggest may in fact in *some* cases be parental, educational and community glosses on 'failing to achieve' academically, or mental health issues which manifest as behavioural problems as an unwell CYP 'acts out' in education settings) is a cause of immense distress for all parties. Indeed as illustrated, particularly in relation to the parental section of the study, it may prove exceptionally difficult (and/or expensive) to obtain an adequate diagnosis and support to enable appropriate interventions to occur, which may in turn lead to a downward spiral of ill-health, negatively impacting the CYP themselves as well as wider family members.

Increasingly common family stresses including divorce, bereavement and (often unacknowledged) parental mental health concerns, in turn adds to the pressures experienced by young people – a theme which as illustrated in the Literature Review (Chapter One) can predispose a young person to mental illness. Such levels of distress are often manifesting (particularly amongst young women) in dramatically and alarmingly increasing levels of self-harm; whilst there is a deeply concerning upturn in suicide (or attempted suicide) amongst both genders, with boys seemingly at most risk of completed suicide – a theme discussed particularly in relation to university students.

Sexual orientation and anxiety or depression relating to gender identity, whilst not in the top five categories of concerns identified nevertheless featured as a strongly

emerging theme amongst respondents. This is particularly so in relation to the wide-spread cultural expectations within Jewish communities of marriage (to a partner of the opposite sex) and the birth of children born to the couple. Within strictly Orthodox communities (as also emerged strongly in the Kofman and Greenfields study in 2017) there are even stronger cultural taboos against an individual 'coming out' as LGBT+ which may lead to suicide or devastating impacts on family function where marriages are arranged. Identifying as LGBT+ may require someone to leave the community as well potentially as having damaging impacts on an entire family's reputation. The powerful impact of campaigner Johnny Benjamin, who has bravely tackled speaking about the challenges on identifying as both Jewish and Gay[48], as well as the work of specialist organisations such as KeshetUK have underlined the especial challenges faced by CYP in this situation. Given the especially high risk of mental illness (including suicide) amongst LGBT+ CYP (see Chapter One – literature review), it is important that despite the discomfort many members of the community feel in relation to discussing this subject, that work continues to provide support for young people struggling to come to terms with their sexual orientation and gender identity

The issue of stigma, deep-rooted, endemic and found across all sectors of the community in relation to mental health difficulties is profound. Distressingly, this study found time and again that the stigma associated with mental illness acted as a profound barrier to help-seeking, with certain conditions being especially stigmatised. The lack of accessible, accurate information about available resources to help CYP and families who are struggling and a widespread culture of secrecy, particularly in relation to eating disorders, and within some sections of the community, has caused untold damage and pain as well as needless, preventable deaths. Urgent work is therefore required to discuss mental health and seek to deliver rapid, effective interventions if our young people are to thrive and the toxic, downward spiral in mental health is to halted or reversed.

Whilst parents and schools in many senses identify similar themes in relation to their concerns over CYP's wellbeing, it was self-evident that they are often far apart in relation to how they are best able to cooperate and understand each other. Miscommunication, at times mistrust, and a sense of frustration were sadly common when findings from these two groups were compared. There is a very clear need for stronger and closer collaboration and understanding to be developed between schools and parents to support CYP in danger of becoming unwell. For university students, who are often away from their families and support networks for the first time, in many ways the situation is both less researched and more likely to spiral out of control rapidly, given the gaps in service provision at universities, and that young people over the age of 18 years are often in limbo in terms of accessing NHS provided mental health support.

Inevitably, the enormous waiting lists, highly variable service provision and exceptionally high thresholds for statutory NHS support (CAMHS and adult services for over 16s) was a prominent theme in this study - and it is here that community

[48] https://www.thecalmzone.net/2017/10/who-is-jonny-benjamin/

designed and delivered services may best fill the lacuna in provision through collaborative working and whole-community discussions on mental health. On this point, although there was some general agreement that there is now more awareness and openness in discussing mental health issues more broadly, there are very clear variables in relation to different sections of the community. For example, there is evidence of some enormously important work and significant investment at denominational level (for example Reform and Liberal Judaism both have CYP mental health and wellbeing leads employed by the overarching denominational body) as well as individual synagogues and Rabbis across all denominations who are undertaking absolutely sterling work in supporting CYP in relation to mental health.

This more centralised approach to supporting CYP in relation to mental health does however need to become more widespread and normalised, to enable both more openness to occur through good example (with Rabbinic leadership key to reaching many families); and importantly to reduce stigma. We would note too on this point, that it is critically important that engagement with the diverse sectors of the community does not seek to adopt a 'one size fits all' common approach, across the board. In particular there is a very real need for tailored engagement with strictly Orthodox communities in relation to mental health and CYP/family wellbeing which takes accounts of community values and expectations. Important work is being undertaken by a small number of specialist, highly discreet and greatly valued organisations (see for example, discussions relating to the impacts on marriage prospects amongst the strictly Orthodox of mental illness) which are often, as a result of their very discretion and client focus, struggling to raise funding to provide much needed holistic services accessible to members of the strictly Orthodox communities who would not otherwise be able to access support.

In conclusion, our findings have indeed identified that there is desperate need for greater provision across the community and that there is an alarming degree of mental illness amongst CYP. We can now, as a community, seek to work together to develop solutions, processes and actions which ensure that future generations are able to access rapid, effective and appropriate support so that CYP can thrive as they grow into adulthood.

Whilst as outlined earlier we provide more detailed proposals in the core findings chapters, our general recommendations (below) seek to engage with issues that were identified within the course of the research, and which we propose should be considered for adoption as a matter of urgency:

- Development of universal mental health education in schools. Schools to access evaluated training programmes which can be shared throughout primary and secondary schools.
- Training should include recognition of the different needs and abilities of children so that responses are tailored rather than conform to a one size fits all model.
- Greater information sharing between organisations and the education sector. School staff are often unaware of resources from within the community. A need

for clear signposting to occur so that parents and pupils can be directed towards support.

- Clusters of schools working together to share resources. This is particularly relevant to primary schools and small schools with limited resources and no counsellors etc.
- Addressing the gap in provision for 16 to 18 years and transition to adulthood, possibly through developing provision under proposals considered in the 2017 Green Paper "Transforming children and young people's mental health provision: a Green Paper".
- Investigation into the mental health needs and experiences of Jewish students at universities to ascertain whether in addition to University provision additional support is required when they are away from home.
- Creation of a website listing all available resources and a helpline from which advice could be sought by CYP, their families and concerned professionals.
- More regular meetings and interaction between the Jewish community and local authority and statutory services concerning mental health provision for CYP.
- Wider community discussions and education (both across and between denominations) delivered to Rabbinic teams, youth services (including youth groups, camps and sports clubs) and parents as well as young people, and education specialists. Overall there is a need for greater awareness of what constitutes mental health problems or learning difficulties and a need for a concentrated drive to break down the widespread stigma pertaining to these conditions.
- Need for, and awareness of, different approaches for different constituent groups – re: strictly Orthodox, mainstream Orthodox and Reform/Liberal/Masorti.
- A need to train and employ (or refer to) younger counsellors across all sectors of the community and in education, synagogue and broader community settings, who are not perceived of as 'establishment' and who are familiar with the stresses, temptations and pressures experienced by young people today.
- A greater role for detached youth workers who can engage with young people on a longitudinal basis in informal settings and monitor wellbeing levels on an individual basis.
- Madrachim: a real need for training and awareness raising amongst youth leaders who are only often a few years older than the young people they take 'on tour' to Israel or work with in camps and who are often lacking in awareness of warning signs or unaware of available support services.

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APPENDICES

1) **Information Sheet**
2) **Consent Form**
3) **Interview Topic Guides (each group of interviewees)**
4) **Focus Group Topic Guide**

Appendix 1 – Information Sheet

PARTICIPANT INFORMATION SHEET

Study title: HEADS UP: Mental Health; Learning Disability and Social Care Services available to Jewish Children and Young People (CYP) living in the London Borough of Barnet

You are being invited to take part in a research study which has been commissioned by the Jewish Leadership Council to find out about the range (and accessibility) of mental health, learning disability and social care services which are available to young people under the age of 25 with a particular focus on services available to those CYP who live in Barnet. Before you decide if you want to be involved (either through completing an on-line survey, or taking part in an interview), it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear, or if you would like more information. Take time to decide whether or not you wish to take part.

If you take part in an **interview or focus group** (see below) you will be **asked to sign a consent form** before the interview/focus group begins. A copy of the consent form will be supplied to you on the date that the interview/focus group takes place. You can at any time decide that you do not wish your interview data to be included in the study (see further below).

Purpose of the study?

The overall project is seeking to

4. Explore the range and number of Jewish community (schools, linked to synagogues and Jewish agencies such as JAMI), secular organisation (including MIND, MENCAP etc.) and public sector (e.g. Children and Family Services; CAMHS) organisations providing mental health, special educational needs and social care services to Jewish youth up to the age of 25 years living in the London Borough of Barnet. We will also include organisations or services beyond Barnet (for example in Camden, Hackney or Hertsmere, and specialist national agencies) used by Barnet residents.

5. To gain an understanding of any problems which may be encountered in relation to access to, and adequacy of provision, as well as how referrals take place.
6. To undertake 20 interviews with a range of the following:
    - **a.** experts working within schools or NGOs;
    - **b.** parents/carers of CYP who have accessed mental health and wellbeing services and who are in contact with specialist organisations providing support to CYP;
    - **c.** representatives of Jewish schools who are interested in discussing mental health, learning disability and social care provision for children and young people.
    - d. Selected young people age 18-25 (pre-screened for risk of vulnerability/ability to provide informed consent) who have either personal experience of accessing mental health and wellbeing services or who are in a role where they may encounter young people who may require support to access such services e.g. acting as a trained community volunteer/Madrachim

Nb: Education professionals (either in one to one interviews or who are invited to attend a focus group) will be asked to reflect on their contextualised experiences of the provision of support for pupils requiring support for mental health/wellbeing, including how (or whether) they were able to facilitate a CYP or family member in accessing external services; challenges to identifying and delivering mental health/wellbeing support (including issues about referrals on and engaging with parents); how they personally (others in the school) deliver or support the provision of in-school services; their training experiences and needs; and recommendations for creating a supportive environment within the school system which balances the educational needs of CYP as well as enabling them to access wellbeing support so as to achieve to the best of their ability.

The project will give a wide range of Jewish community groups; service providers; education professionals and parents an opportunity to talk about their perceptions of available mental health, learning disability and social care services; referral pathways and support available to the communities. In particular we are keen to explore how effective existing services are in meeting the needs of children and young people, whether there is a need for additional provision such as tailored services aimed at the diverse Jewish communities, or if new methods or pathways are required to increase access to services for young people needing assistance.

Confidentiality and anonymity

Your name will not be used or associated with anything you say or do in the study without your express permission (for example if you wish your organisation to be named/identified). You may choose to end your participation in this study at any time and there will be no negative consequences.

All information that is collected during the course of the research will be kept strictly confidential. Any information about you which is used will have your name removed so that you cannot be recognised from it. You will not be identified in any reports or publications resulting from the study In addition, all data all data will be stored, analysed and reported in compliance with the Data Protection Act 1998.

Results of the research study?

All recordings and transcriptions of the interview will be stored in line with Data Protection Act requirements and destroyed once the relevant information has been extracted and the required data storage period has expired.

Ethical Approval

This study has been reviewed and approved by Middlesex University, School of Law Ethics Committee.

Contact for further information

You can obtain further information about the research from Professor Eleonore Kofman, email: e.kofman@mdx.ac.uk or Professor Margaret Greenfields, Margaret.Greenfields@bucks.ac.uk

Thank you for taking time to read this information and considering whether to take part in this important research.

Appendix 2 – Consent Form

Consent Form

HEADS UP: Mental Health and Social Care Services available to Jewish Children and Young People (CYP) living in the London Borough of Barnet

I …….. (print name) **confirm** that:

- I have read and understood the information enclosed, and the nature and purpose of the research project has been explained to me. I confirm that I have had opportunity to ask questions.
- I understand that participation is voluntary and I can withdraw from the interview at any time, or may refuse to answer any questions, without having to give an explanation
- I understand that all information about me will be anonymised and remain confidential, and that I will not be named or identifiable in any written work arising from this study without my express permission.
- I understand that any information including direct quotes given by me may be used anonymously in future publications, reports, articles or presentations.
- I agree to the interview being audio recorded. I understand that all materials will be held in compliance with the Data Protection Acts.
- I understand that any digital recording of me will be used solely for research purposes and will be destroyed on completion of the research and required data storage period.
- I understand that this project has been approved by Middlesex University' Ethics Committee.
- I **agree to be interviewed** for this research study.

Participant's name: _____ **Signature:** _____

Date: _____

Appendix 3 – Topic Guides

HEADS UP: Mental Health and Social Care Services available to Jewish Children and Young People (CYP) living in the London Borough of Barnet

TOPIC GUIDE: Interviews with Education Specialists

- What kinds of problems/areas of concern do they think are particularly impacting Jewish CYP in Barnet/their locality at the moment?
    - Probe re diagnosis change, e.g. any particular perceptions re level of learning disabilities or prevalence of particular conditions requiring social care support etc.?
    - Probe on MH stressors/concerns - eating disorders, self-harm, substance abuse, online abuse, domestic violence, familial related mental health issues; gender identity/sexuality associated with mental health difficulties; school/social media issues - including sexting, bullying, school problems, general anxiety re media 'overload', etc.
- Information on types of services provided by school? e.g. LD; MH; other social care…
- Examples of typical types of cases and pathways which would be followed e.g. referral to services provided by communal organisations (e.g. school counsellors) or statutory services (e.g. CAMHS) OR specialist (non-Jewish) organisations such eating disorder charities; MIND; etc.
    - Probe re issues around delivery of services e.g. waiting lists referrals on, cost etc.? available pathways? Cultural issues if delivered outside community

SATISFACTION WITH SERVICES AVAILABLE TO PUPILS

- Perceptions of (and personal experiences) of any difficulties in accessing support for CYP

    - (probe – re whether feel easier/harder to access Jewish community provided services; issues around cultural accessibility; quality of services – and conversely worries over confidentially)
- Perceptions of statutory services – positive and negative e.g. high thresholds, waiting lists; limited capacity, perceived gaps in a pathway, etc.
- Perceptions and Use of Not specifically Jewish private sector services – e.g. psychotherapy; privately financed social care support; educational support for LD etc.. range of choices; privacy; quality; etc. (level of cultural awareness?)
- Degree of awareness of available services? How became aware of these? What would like to see developed (and why/history of service offer in school setting)
- Preferred agencies for referrals on?
    - Nb: have they provided or shared information re services/access/problems with other members of the Jewish community – e.g. advice, recommendations, guidance on accessing particular services – or those to avoid?
    - Which services would they particularly recommend and why?
    - Which to avoid and why?

- Probe re appropriateness of available services (across sectors: statutory, Jewish community provided and other NGO/private services) what could be amended/developed to improve service provision? E.g. earlier interventions; differential pathways etc.?
- Probe re quality and type of relationships with services/what would help to improve – or any difficulties (within and outside Jewish communities)
- Recommendations for good practice – based on experience of service provision – whether would prefer a particular model provided by the community or to simply use statutory services – why?

- Any Information which they can share on other services/good practice elsewhere in London/UK/World which might be relevant in terms of service development?

Other

THANK AND CLOSE

HEADS UP: Mental Health and Social Care Services available to Jewish Children and Young People (CYP) living in the London Borough of Barnet

TOPIC GUIDE: Interviews with Specialist Agencies/NGOs

- Background on services provided with specific reference to MH/LD/Wellbeing/Social Care
    - Probe re how/why might offer specialist activities and why needed

- What kinds of problems/areas of concern do they think are particularly impacting Jewish CYP in Barnet/their locality at the moment?
    - Probe re diagnosis change, e.g. any particular perceptions re level of learning disabilities or prevalence of particular conditions requiring social care support etc.?
    - Probe on MH stressors/concerns - eating disorders, self-harm, substance abuse, online abuse, domestic violence, familial related mental health issues; gender identity/sexuality associated with mental health difficulties; school/social media issues - including sexting, bullying, school problems, general anxiety re media 'overload', etc.
- Examples of typical types of cases and pathways which would be followed e.g. referral to services provided by communal organisations (e.g. school counsellors) or statutory services (e.g. CAMHS) OR specialist (non-Jewish) organisations such eating disorder charities; MIND; etc.
    - Probe re issues around delivery of services e.g. waiting lists referrals on, cost etc.? available pathways? Cultural issues if delivered outside community

<u>SATISFACTION WITH SERVICES AVAILABLE TO CYP – delivered by range of agencies</u>

- Perceptions of (and personal experiences) of any difficulties in accessing support for CYP
    - (probe – re whether feel easier/harder to access <u>Jewish community provided services</u>; issues around cultural accessibility; quality of services – and conversely worries over confidentially) – seek to differentiate if necessary by sectoral use within Jewish community (e.g. would they refer to Norwood or Kisharon? etc.)

- Perceptions of statutory services – positive and negative e.g. high thresholds, waiting lists; limited capacity, perceived gaps in a pathway, etc.
- Perceptions and use of Jewish community provided services – positive and negatives (familiarity with specific services such as those delivered by Jami etc.)
- Perceptions and Use of Not specifically Jewish private sector services – e.g. psychotherapy; privately financed social care support; educational support for LD etc.. range of choices; privacy; quality; etc. (level of cultural awareness?)
- Degree of awareness of range of available services? How became aware of these? What would like to see developed (and why? History of development of own service offer if necessary)
- Preferred agencies for referrals on?
    - Nb: have they provided or shared information re services/access/problems with other members of the Jewish community – e.g. advice, recommendations, guidance on accessing particular services – or those to avoid?
    - Which services would they particularly recommend and why?
    - Which to avoid and why?

- Probe (if not dealt with above) re appropriateness of available services (across sectors: statutory, Jewish community provided and other NGO/private services) what could be amended/developed to improve service provision? E.g. earlier interventions; differential pathways etc.?
- Probe re quality and type of relationships with services/what would help to improve – or any difficulties (within and outside Jewish communities)
- Recommendations for good practice – based on experience of service provision – whether would prefer a particular model provided by the community or to simply use statutory services – why?
- Any Information which they can share on other services/good practice elsewhere in London/UK/World which might be relevant in terms of service development?

Other

THANK AND CLOSE

HEADS UP: Mental Health and Social Care Services available to Jewish Children and Young People (CYP) living in the London Borough of Barnet

TOPIC GUIDE: Interviews with Parents/Carers

- What kinds of problems/areas of concern do they think are particularly impacting Jewish CYP in Barnet at the moment?
    - Any particular perceptions re level of learning disabilities or prevalence of particular conditions requiring social care etc.?
    - Probe on MH stressors/concerns - eating disorders, self-harm, substance abuse, online abuse, domestic violence, familial related mental health issues; gender identity/sexuality associated with mental health difficulties; school/social media issues - including sexting, bullying, school problems, general anxiety re media 'overload', etc.
- Whether they have had personal experience of family members (CYP) using MH; LD or Social Care Services
- What type of services used? E.g. LD; MH; other social care…
- Whether services accessed were provided by communal organisations OR within education settings (e.g. school counsellors) OR statutory services (e.g. CAMHS) OR specialist (non-Jewish) organisations such eating disorder charities; MIND; etc.
    - Probe if used mixture of services – if so why? Referrals on, cost etc.? available pathways?

SATISFACTION WITH SERVICES ACCESSED BY FAMILY MEMBER - IF APPROPRIATE

- Perceptions of (and personal experiences) of any difficulties in accessing support for CYP
    - (probe – re whether feel easier/harder to access Jewish community provided services; issues around cultural accessibility; quality of services – and conversely worries over confidentially)
- Perceptions of statutory services – positive and negative e.g. high thresholds, waiting lists; limited capacity, perceived gaps in a pathway, etc.
- Perceptions and Use of Not specifically Jewish private sector services – e.g. psychotherapy; privately financed social care support; educational support for LD etc. range of choices; privacy; quality; etc (level of cultural awareness?)

- How would they go about finding out about MH/LD and SC services if required?
- Other agencies familiar with/used/ or accessed for referrals on?
    - Nb: have they provided or shared information re services/access/problems with other members of the Jewish community – e.g. advice, recommendations, guidance on accessing particular services – or those to avoid?
    - Which services would they particularly recommend and why?
    - Which to avoid and why?

- Probe re appropriateness of available services (across sectors: statutory, Jewish community provided and other NGO/private services) what could be amended/developed to improve service provision? E.g. earlier interventions; differential pathways etc.?

- Any Information which they can share on other services/good practice elsewhere in London/UK/World which might be relevant in terms of service development?

Other

THANK AND CLOSE

HEADS UP: Mental Health and Social Care Services available to Jewish Children and Young People (CYP) living in the London Borough of Barnet

TOPIC GUIDE: Interviews with Young People 18-25

- Discuss how came to be interviewed/personal experience of using MH; LD or Social Care Services
- What type of services used? E.g. LD; MH; other social care…
- Route into services e.g. via Rabbi, word-of-mouth from family/friends or within/via education settings (e.g. school counsellors) OR statutory services (e.g. CAMHS) OR specialist (non-Jewish) organisations such eating disorder charities; MIND; etc.
    - Probe if used mixture of services – if so why? Referrals on, etc.? Available pathways?

SATISFACTION WITH SERVICES ACCESSED - IF APPROPRIATE

- Perceptions of (and personal experiences) of any difficulties in accessing support
    - (probe – re whether feel easier/harder to access Jewish community provided services; issues around cultural accessibility; quality of services – and conversely worries over confidentially)
    - Probe re support within school settings
- If relevant - Perceptions of statutory services – positive and negative e.g. high thresholds, waiting lists; limited capacity, perceived gaps in a pathway, etc.
- If relevant - Perceptions and Use of Not specifically Jewish private sector services – e.g. psychotherapy; privately financed social care support; educational support for LD etc.. range of choices; privacy; quality; etc. (level of cultural awareness?)
- Other agencies familiar with/used/ or accessed for referrals on?
    - Nb: have they provided or shared information re services/access/problems with other CYP from the Jewish community (or outside of it) – e.g. advice, recommendations, guidance on accessing particular services – or those to avoid?
    - Which services would they particularly recommend and why?
    - Which to avoid and why?

- Probe re appropriateness of available services (across sectors: statutory, Jewish community provided and other NGO/private services) what could be amended/developed to improve service provision? E.g. earlier interventions; differential pathways etc.?

• General Questions - what kinds of problems/areas of concern do they think are particularly impacting Jewish YP in Barnet at the moment?

o Probe on MH stressors/concerns - eating disorders, self-harm, substance abuse, online abuse, domestic violence, familial related mental health issues; gender identity/sexuality associated with mental health difficulties; school/social media issues - including sexting, bullying, school problems, general anxiety re media 'overload', etc.

- Any information/recommendations which they can share on other services/good practice which might be relevant in terms of service development?

Other

THANK AND CLOSE

Appendix 4 - Focus Group with SENCOs and School Representatives

Info sheet pre-sent but take spares in case anyone needs to read again.

Consent forms to be signed (or verbally agreed on audio)

EXERCISE

Required: post-it notes (multiple colours if possible); marker pens; several flip-chart sheets

On table or wall – prepare and place three large sheets of flip-chart paper – headed with the themes/topics listed below:

Using post-it notes/stickies (distribute stack for each participant/ensure pens are available) – ask people to write down as many points as they'd like to flag up under the three headings

Ask participants to place each of their post-in notes (can be more than one for each category if multiple issues identified) on the relevant chart

CONCERNS (what are your main concerns in relation to your students: wellbeing/mental health etc.)

nb: probes [only use one or two examples if participants really stuck and can't come up with ideas once commenced the exercise]: 'fad behaviours'; poor parenting; social media pressures etc.

PRIORITIES (what you want or need to change most urgently to support pupils with mental health/wellbeing issues**) probes:** e.g. resources; training; support from parents; Governors, more open dialogue re certain issues, etc.

CHALLENGES (what needs to be overcome to improve pupil wellbeing and mental health in the school setting**) probes;** attitudes towards stigma; institutional barriers; impact on other pupils etc.…

Once completed this element of the exercise can match across to top priorities/ which are

'individual' 'collective' concerns and if any variation by school/gender and age group.

Discuss the themes collectively and use this as a jumping off point for the more in-depth discussions to follow.

FOCUS GROUP QUESTIONS (In addition to questions above)

Select most relevant questions from those below based on above shape of discussion and timing available…

How can schools and individual professionals within schools such as social workers/counsellors etc. collaborate with external agencies such as CAMHS; JWA; Norwood, etc. (a multi-disciplinary approach) to support students with mental health/social functioning/family difficulties which impact on wellbeing?

What role do teachers/ (and other relevant in-school colleagues) have to play in supporting pupils with mental health difficulties? **PROBE** re tensions of role given primarily educators….

How does the school support pupils with mental health difficulties during the transition process (to secondary school or on leaving school)? Are there areas where real challenges exist? Areas for improvement? **PROBE as appropriate** re LD which doesn't reach the 'obvious' threshold for intervention but can cause tensions/stressors for CYP leading to mental health – also issues around disabled siblings/parents etc. leading to mental health/anxiety etc.

What's working well in terms of supporting pupils?

What's not working well?

STAFF TRAINING required (ask to rank training/learning needs giving each request a number 1-5 with 1 as highest priority – can do on stickies again or simply discuss and go around the room)

What would be helpful in terms of discussions within the overall education sector in relation to holistic engagement? **E.g**. what would you like pupils/parents to know by the time a child starts at your school? And when they leave – this links to transition to university or other forms of education such as apprenticeships….

Issues around **leadership** in schools….nb: links to what works well, not so well and relationships between 'feeder schools' and to some extent demographics of pupil body/parents/degrees of Orthodoxy….

Wellbeing of staff…? Challenges in supporting CYP and trauma when things go badly wrong…

Recommendations to share with JLC?

Recommendations to share with other schools?

Recommendations to share with other multi-agency partners – such as Jewish agencies and/or CAMHS etc.?

What can the Jewish community do as a collective whole (if anything) to strengthen CYP wellbeing?