The role of faith in mental health

A report of six focus groups with Redbridge faith communities

February 2009

There is no health without mental health

One adult in four suffers from a mental health problem

Significant depression is present in 15% of older people.

Suicide is still the biggest cause of death in young men.

By Roxanne Keynejad

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Redbridge Faith Forum
Respect Co-operation Understanding

supported by Redbridge Council

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Foreword

The Redbridge Faith Forum in partnership with Redbridge Concern for Mental Health and funded by the London Borough of Redbridge undertook this project to explore the enthusiasm and need for mental health training within the faith sector.

We held six mental health focus groups in different faith locations so we could find out the experiences and needs of the faith sector with respect to Mental Health. The whole process was an enriching and valuable learning experience for all of us who took part.

We discovered how much we have in common across faiths, when it comes to issues such as stigma, discrimination, guilt and shame that arise from our common experiences as humans with mental illness.

We also found out how much we share in common of the resources that faith can bring to bear as we face the pressures, stresses and strains of life in a busy London borough like Redbridge, such as prayer, meditation, counselling and a listening ear, provided by so many of the volunteers who make up our faith communities.

We would like to thank Roxanne Keynejad, a former colleague at Redbridge CVS, for putting together this excellent report; Jon Abrams and his colleagues at Redbridge Concern for Mental Health for the support for this project; and the faith forum management committee and staff for taking the trouble to arrange the venues for the focus groups and inviting members of their faith groups to attend the meetings.

The success of the proposed work will require commitment and work on behalf of commissioners, those providing services and faith communities as well as voluntary and community organisations. We hope that the NSF Local Implementation Team will play a key role in ensuring the delivery of mental health training for the faith sector. Redbridge Faith Forum is keen to be associated with this project and to work with other partner agencies to deliver this kind of training.

Councillor Filly K. Maravala
Chair of Redbridge Faith Forum

> **“I think there is a real benefit for bringing all the communities together so people understand that we’re all in the same boat, there’s something overall that we could talk about in terms of stigma, that’s going to be right across the board I would imagine.”**
>
> Focus group participant

Summary

This report outlines the findings of six focus groups with faith communities in Redbridge on the subject of mental health and the need for training on the subject.

Introduction

Redbridge is an ethnically and religiously diverse borough which from mental health inequalities. These may be partially due to ethnic minority and other groups waiting longer than White British groups to seek help for mental health problems. It has long been identified that faith and spiritual communities can play a pivotal role in improving mental health and access to treatment but this has not been explicitly explored or acknowledged in Redbridge.

The Redbridge Faith Forum in partnership with Redbridge Concern for Mental Health and funded by the London Borough of Redbridge undertook this project to explore the enthusiasm and need for mental health training within the faith sector. This is in keeping with priorities at national and local levels and is encouraged by academic research on the subject.

The project's aims were:

1. To find out the views, opinions and experiences of faith leaders and congregants with regards to mental illness and mental health.
2. To find out the needs of faith leaders with regards to mental health training.
3. To engage with faith communities in order to capture their understanding of the challenges they face and the actions that would help in overcoming them.
4. To use the information and ideas to design a mental health training programme.

62 participants took part in six mental health focus groups with the Buddhist and Zoroastrian, Christian, Hindu, Jewish, Muslim and Sikh faiths in community locations. Their discussions were transcribed and brought together to identify the following conclusions.

> **"I don't think we can separate mental and spiritual health. Many people come to me because they want to see someone who is a (religious) Muslim and a trained psychotherapist."**
>
> Focus group participant

Conclusions from Focus Groups

Conclusion 1

Faith communities provide significant social support to people suffering from mental health problems. Spirituality plays a crucial role for many people experiencing distress in their lives. Furthermore, spiritual practices from prayer to yoga and meditation provide comfort and a focus for recovery. Religion provides sense of belonging, hope, sense of control and coping mechanisms, all of which are fundamental to good mental health. Faith workers are at times put in a position in which they must play a role in emergency care of a person in crisis and often take on informal roles as counsellors.

Conclusion 2

In faith communities, people feel guilt and shame for having mental health problems and some will not seek help there. Others feel more comfortable seeking help from their faith

community and struggle to seek help from statutory services. Stigma and fear mean that people are misinformed about the nature of mental health services or feel unable to talk about mental health problems in the way that they can about physical health problems. Many people are surprised by how common mental ill health is, because it is so infrequently talked about. This is likely to be the same for related problems such as substance misuse.

Conclusion 3

Many faith workers were unsure how to recognise people needing help for mental health problems among their congregants and how to support them. They want to be more confident in who they can refer people to and to better understand the services available so that they can encourage people to use them. They want training both from people from their own community (and in some cases in their first language) and from service users. They also asked for training that covers preventative measures to improve mental health at an early stage, particularly with young people and issues affecting them such as substance misuse.

Conclusion 4

The faith workers felt that training must include basic information and education which they could then disseminate in their communities. They need to know what services are available, how to navigate them for themselves and loved ones and how well trained groups such as the Police are, to understand mental ill-health. Their communities need to know more about the nature of mental health problems and for some ethnic minority groups for that to be explored in their first language. People need more information to reduce their levels of fear of mental health problems and treatments and they want it to be delivered in the community.

Conclusion 5

Participants are very aware of the limits of support they as faith workers can provide. They identified a key role for themselves in providing support and understanding and referring congregants to statutory services, spiritual forms of solace where appropriate (including traditional forms of medicine) and voluntary sector organisations. They want to know to whom and how to refer people quickly and efficiently without leaving them to be referred endlessly from one team to another.

Conclusion 6

Alternative beliefs about the cause of mental health problems (including possession) are prevalent within ethnic minority faith communities in and in some cases prevent people from seeking help from statutory services. For this reason many of these people feel that only a member of their own faith or ethnic group will understand their needs. For this reason faith workers can play a pivotal role in supporting and encouraging people dealing with mental health problems to make the transition to using statutory services.

Conclusion 7

Faith communities are flexible and provide services in different languages, organise groups and clubs for different people and some faith organisations have the scope to provide their own therapy services. The experience of collaboration between different faiths working towards the same goal is evidence of the creativity and enthusiasm within the faith sector which remains underutilised by mental health services.

Conclusion 8

Faith workers feel strongly that there is scope for joint working between them and statutory mental health services but have struggled to establish links and contacts. There is an important role for faith groups in training mental health workers in cultural and spiritual awareness and understanding but also for mental health workers in training the faith sector.

Conclusion 9

Some participants felt that only mental health professionals from their own cultural or spiritual background can understand their needs.

This implicates an important intermediary role for faith workers, who are , to gradually refer people on to statutory services by explaining how the system works and raising awareness of accessibility, for example, the widespread use of interpreters.

Conclusion 10

Different faith workers identified a range of challenges facing themselves and their congregants. These included the pressures of modern life, both for the working generation and the elderly, family problems, forced marriage, comparison with others, loneliness and isolation, language difficulties, worry about children's safety and substance misuse. For faith workers there is also the challenge of serving a very large population and having limited resources with which to support them.

Conclusion 11

There are real benefits, demonstrated by the success of the focus groups, for delivering some mental health training sessions in faith-specific groups. However, an event which brings together all the relevant stakeholders to share what has been learnt and encourage future collaboration would be very valuable.

> **"My father wouldn't take the help because he didn't like the look of him [health professional]. What made the difference was talking, speaking the same language. He started by talking about back home."**
>
> Focus group participant

Recommendations

1. Redbridge Faith Forum (RFF) working in partnership with Redbridge Concern for Mental Health (RCMH), Anxiety Care, Redbridge Equalities and Communities Council (RECC) and Redbridge CVS (RCVS) should plan a mental heath training programme in spring 2009. This should be to faith leaders and other faith workers from the different religious and spiritual groups represented in the Redbridge population during 2009/10. This training should aim to develop the capabilities of faith leaders and faith workers in understanding mental health problems and the needs of their community. The planning should include working out the number and duration of training sessions and what trainers/ facilitators would be needed.

   Once available funding is established, a working party should be set up to help plan the training courses, to include RFF, RCMH, RCVS, Anxiety Care and RECC, with representatives of North East London NHS Foundation Trust (NELFT), interested faith leaders and people involved in similar training in other local boroughs, such as Newham.

2. Designated local workers in Redbridge should be trained on a Mental Health First Aid training course as run by the National Institute for Mental Health (see 7.0: Appendix 1) in spring 2009. This course could provide the template for the training which they would deliver to faith community leaders in Redbridge.

   However, an important question for the working group recommended in 1. would be whether Mental Health First Aid is the most appropriate form of training for faith communities and whether it allows sufficient flexibility to address the culture-specific concerns identified in this report.

3. Important topics to be covered by the training could be:

   - Key mental health problems and how they can manifest themselves.
   - What to do when helping a person suffering from a mental health crisis.

- Information about the prevalence of mental health problems in the community.
- Clear outlines of how mental health services work and how they can be accessed, including the opportunity to hear from mental health service users and mental health practitioners. Where possible and appropriate, these individuals should be members of the faith community in question.
- How to know when a person needs to receive professional help and when to refer them to statutory services.
- How to tackle stigma and discrimination in the community.
- Specific information about reliable ways to refer a person to mental health services.
- Discussion of how to help a person to use statutory services when they feel only someone of their culture will understand them.
- Advice on working with young people and positive preventative measures.
- Discussion of ways to increase knowledge and understanding about mental health problems within the community.
- Where appropriate, discussion of how to reconcile belief in spiritual possession with seeking medical treatment for mental health problems.
- Acknowledgement of the challenges faith workers will face and ways for them to cope with the distressing things they may experience in supporting their community.

4. In designing this training programme there should be opportunities for mental health practitioners to interact with the faith communities, to encourage partnership working and sharing of skills. At the higher management level of the North East London NHS Foundation Trust, the Local Implementation Team and the Redbridge Primary Care Trust it must be explored how best to establish direct care pathways from key faith leaders to Community Mental Health Teams.

5. After the training sessions have been delivered (subject to appropriate funding) there should be an event, which brings together all key stakeholders from the faith and statutory sectors, to share what has been learnt and to evaluate the training. After a period of three months all participants should be surveyed to determine what benefits the training has had.

6. If considered effective, the training should be rolled out to additional groups of faith workers and a 'train the trainers' programme, which enables the community to be in charge of spreading awareness, should be explored.

7. Redbridge Faith Forum should organise a public forum on mental health issues in spring 2009 to discuss the issues arising from this report.

Finally

This report clearly demonstrates the genuine enthusiasm for, interest in and need for mental health training in the faith sector in Redbridge. It highlights the significant role already played by faith communities in promoting one another's mental health and the very real scope for expansion of partnership work and development of explicit care pathways between faith organisations and mental health services.

It is suggested that a well-tested model such as Mental Health First Aid training be explored as a pilot but for there to be room for the training to be more specifically tailored to the needs of the individual faith groups. This presents a simple, cost-effective and valuable opportunity to make real steps towards delivering genuine equality in mental healthcare, not just for ethnic minority groups, but for all.

Introduction

Redbridge Profile

Redbridge is the ninth most ethnically diverse local authority in England and Wales (2001 Census). GLA population projections reveal growing percentages of ethnic minority groups, with corresponding growth in the borough's religious and cultural diversity.

In 2001, Redbridge had the fourth highest percentage of Hindu, Jewish and Sikh residents in England and Wales, the twelfth highest percentage of Muslim and the tenth lowest percentage of Christian residents. The Redbridge Faith Forum was established in 2003, to give faith communities a collective voice by bringing together representatives of different faiths, gaining mutual understanding, discussing local issues and promoting social cohesion.

Religion	Number	Percentage
Christian	121067	50.7%
Muslim	28487	11.9%
No religion	22952	9.6%
Hindu	18661	7.8%
Jewish	14796	6.2%
Sikh	13022	5.5%
Buddhist	1052	0.4%
Other	1038	0.4%
Religion not stated	17560	7.4%

Mental Health Inequality and the roles of Spirituality and Faith

Redbridge's mental health services, like most of those in the region, show a worrying over-representation of service users of Black Caribbean, Black African and Other Black people, and an under-representation of Asian people. Both statistics indicate disparities in understanding of mental health problems and knowledge of the services available in these key ethnic minority groups. There is also widespread fear of seeking help and of mental health services generally among ethnic minority communities.

A recent report, 'Barriers to Seeking Help: What stops ethnic minority groups in Redbridge accessing mental health services?' published by RedbridgeCVS (2008) found that religious faith and belief play a critical role in the mental health of Redbridge communities, including White British groups.

This was not a new observation. The National Institute for Mental Health in England and the Mental Health Foundation both have projects around the role of spirituality. Despite high profile discussions of this issue, however, such as Nigel Copsey's report, Keeping Faith, for the Sainsbury Centre for Mental Health, spirituality has remained a neglected issue. Keeping Faith investigated the spiritual needs of ethnic minority groups in the neighbouring borough of Newham:

> I spoke with many users of day services. In our discussions it was clear that their particular beliefs were very important to them. However, there was a fear regarding talking about those beliefs because it was thought that if they did so, they would either be sectioned, placed on medication, or seen as exhibiting psychotic symptoms.
>
> Many mental health workers with whom I spoke saw the whole complexity of religious beliefs as far too complicated to engage with, and many saw religious belief as contributing to mental health problems… In all these situations, those who sought help went first to their Faith Community. One very deeply religious man to whom I spoke, who was severely depressed, went once to the day hospital but 'God was never mentioned'. He didn't return.

The commonly reported view that faith may contribute to mental health problems is a worrying one since there is a growing body of evidence to suggest that spiritual-

ity is beneficial for mental health and recovery (e.g. Pardini et al. 2000). Copsey continues:

> Many people to whom I spoke, drawn from all religions, said they dreaded going into a hospital or day centre because there was nothing in those buildings which enabled them to express their faith. When I asked what they wanted, many said they wanted a place for prayer, contact with their religious community, and staff who wanted to talk to them about their faith. One person told me that having been to a day centre once, she refused to return as she felt so cut off from the things that mattered most to her.
>
> This difference cannot be overstated as it constitutes what I believe to be the fundamental reason as to why there is so little integration between the community mental health services and the new communities. The belief system underpinning nearly half the population of Newham is grounded in non-western culture. This culture has a long history of integration between the body, mind and spirit. Spiritual values are an essential part of life. There is no dichotomy between the secular and the spiritual. Life is sacred. The transcendent is part of life. Such a belief system permeates the whole of life. This is very hard for those with a western world view to understand.

Learning from this excellent project in Newham, Redbridge mental health services must acknowledge the critical role of spirituality in the recovery and general wellbeing of many ethnic minority communities if they are to Deliver Race Equality.

Project Aims

In 2008 Redbridge Faith Forum (RFF) obtained a grant from the London Borough of Redbridge to investigate the views of local faith communities about mental health awareness and gain their input into potential future training courses.

In collaboration with Redbridge Concern for Mental Health, RFF organised six focus groups with key religious groups in order to find out the views of these communities on mental health. This report summarises the findings of this project and sets out corresponding recommendations for the mental health training programmes, which will be designed in future.

The project's aims were:

1. To find out the views, opinions and experiences of faith leaders and congregants with regards to mental illness and mental health.
2. To find out the needs of faith leaders with regards to mental health training.
3. To engage with faith communities in order to capture their understanding of the challenges they face and the actions that would help in overcoming them.
4. To use the information and ideas to design a mental health training programme.

> **"I feel faith is important. [When I was depressed] I believed in God, prayed to god ten times more. I think it helped a lot."**
>
> Focus group participant

The National Context

The agenda of including faith workers (both paid faith leaders and volunteers who play a key role in places of worship and in communities) in mental health awareness and promotion is in keeping with several key local and national priorities.

The National Service Framework for Mental Health (1999)

A key piece of mental health guidance, it highlights the importance of the "spiritual facets of

mental health and mental health problems" under Standard 1 (mental health promotion). Standards 4 and 5 (effective services for people with severe mental illness) raise the importance of acknowledging a service user's spiritual needs and beliefs when making an assessment and planning their care.

Delivering Race Equality (2005) is a pivotal mental health agenda highlighting the large inequalities in mental health among ethnic minorities in British society. Its three key building blocks are addressed by this project, better mental health awareness among spiritual leaders ensures better information and community engagement.

Furthermore, by creating partnerships between faith communities and mental health services, we will develop opportunities to make services more appropriate and responsive to the needs of faith groups:

More appropriate and responsive services – achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups.

Community engagement – delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers; and

Better information – from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services.

It is hoped that greater awareness about mental health among faith communities will encourage earlier help seeking and earlier intervention of services in mental health problems. By extension this should reduce the number of people from faith communities reaching a point of crisis in their illness and therefore we hope to reduce both the need for inpatient admission and the need for compulsory detention. These are perhaps tall orders, however we consider this project a pilot to illustrate the potential benefits of greater mental health awareness in hard-to-reach faith communities and if successful, we would hope to expand the training to include a larger number of faith leaders, in order to maximise the project's impact.

Religion or belief: A practical guide for the NHS (2009)

This new document highlights the role of faith:

Research suggests that attention to the religious and cultural needs of patients and service users can contribute to their wellbeing and, for instance, reduce their length of stay in hospital. Religion and belief are therefore important considerations for all patients and staff.

> **"We have a network of supporters. We have a tradition of looking after the elderly, the unwell and when people are bereaved. We alleviate some of the primary things that lead to depression."**
>
> Focus group participant

The Local Context

The goals of the ***Redbridge Sustainable Community Strategy*** fit in with the objectives of this project. One of its four 'overarching priorities' is to 'strengthen community cohesion'. Currently faith groups are isolated from statutory mental health services as well as from each other. This project brings together a diverse set of religious communities to encourage better partnership and cohesive working with all important stake holders in local mental health.

NHS Redbridge Draft Strategic Plan 2008/09 – 2012/13

This document includes the National Health Service Redbridge Initiatives, including:

Initiative 5: Partnership/Borough Development: Ensuring a stronger focus on partnership services for children, people with disabilities, people with mental health needs, and other vulnerable adults by redesigning and strengthening our approach to partnership working and ensuring we work even more closely with LBR and other borough partners including the voluntary and community sector to gain significant improvements in outcomes for services users and carers.

Locally, this project fits well with the North East London NHS Foundation Trust (NELFT)'s ***'Helping you live the life you want' Integrated Business Plan 2008/9 – 2012/13:***

- ***Healthy Communities*** – the Trust will work with the membership to break down the barriers and stigma experienced by service users. The Trust will harness the views and experiences within the membership and Council of Governors to share information, increase awareness and develop well being and prevention programmes.

- ***Investing in local priorities*** – the Trust will use the financial freedoms of a Foundation Trust to maximise investment in local services and engage the membership and Council of Governors in shaping future plans so that the right investments and changes are made which meet the diversity of local need.

The Redbridge Mental Health Promotion Strategy (2007)'s priorities include:

- Creating or linking into a community based network to deliver mental health promotion
- Improving awareness of mental health issues
- Tackling stigma and discrimination

The Academic Evidence

Academic research in the growing field of mental health and spirituality has suggested a positive relationship between religion and mental and physical health. Sims (2004) summarised the findings:

> One of the best-kept secrets of modern epidemiological medicine is the effect that religious belief and practice have upon outcome from both physical and mental disorders. Twelve hundred outcome studies and 400 critical reviews have formed the subject matter of the *Handbook of Religion and Health* by Koenig *et al* (2001). On all of the 13 factors for improved mental health, religious belief proved beneficial in more than 80% of studies, despite very few of these studies having been initially designed to examine the effect of religious involvement on health.

There is evidence based on qualitative interviews that both Orthodox Jews and Muslims are reluctant to use mainstream psychiatric services. In terms of Orthodox Jewry, Lowenthal (2006) discusses barriers in the strictly Orthodox Jewish community in the UK to help seeking for psychiatric problems. These barriers chiefly include stigma, concerns about violating Jewish religious law and other concerns about conflicts between the values inherent in psychotherapy and Jewish values. Psychotherapy, psychology, psychiatry and psychoanalysis tend to be associated with strong concerns about how "kosher" (religiously acceptable) it is to use these services.

For people of many faiths, having a psychiatric history may impact negatively on future marriage prospects and is thus stigmatising. Psychiatry and psychology can be held to be atheistic, godless and thus many faith groups are wary of any interaction with these disciplines.

Lowenthal (2006) points out that rabbis are overwhelmed with pastoral and counselling work and that they would welcome more professional support. Clients often travel a long

distance from home in order to keep their identities anonymous. They also use cultural sensitive services specially organised by their own faith community (Lowenthal and Brook Rogers 2004).

An anthropological study of attitudes towards psychiatry amongst Bangladeshi Muslims in East London (Dein, Alexandra & Napier, 2008) found distrust of mainstream psychiatry. The community saw psychiatric services as custodial and stigmatising. Few would readily admit to having attended psychiatric consultations and felt mainstream psychiatrists did not understand their culture nor their needs.

Much psychiatric illness was expressed in the idiom of spirit possession by Jinn spirits. Rather than seeking psychiatric help, members of the community frequently attended Imams and traditional healers (often at great expense). This research emphasises the need for British psychiatry to incorporate a cultural perspective when working with Muslim clients.

There is emerging evidence that Islamaphobia may have significant negative effects on the mental health and healthcare of Muslim families and children. Despite pleas from service users in local Muslim communities for mental health professionals to take their religious and spiritual needs into account, the literature suggests that services fail to meet such needs (Greasley et al 2001). This is not surprising since mental health professionals receive minimal training on the role of spirituality.

At the same time, religious leaders have indicated that they need help in understanding and addressing their congregants. Many imams and rabbis have pointed out their lack of knowledge about mental illness and their desire to learn more. Loewenthal (2006) argued that rabbis often feel overwhelmed by the number of congregants approaching them for psychological help. Imams have suggested that they would like to attend courses on mental health (Dein, Alexander & Napier 2008).

Some people have very negative experiences of their mental health problem being ascribed to Satan, demonic possession or other spirits and some endure unpleasant ceremonies to get rid of the 'spirit'. For those who do not want such 'cures' this only adds to the feelings of isolation and abnormality. Much of this could be remedied by ensuring better information and understanding about mental health problems and services within faith communities. Whilst traditional beliefs are very entrenched and likely to remain, it is important to ensure that everyone has as much information available to them as possible and that faith leaders become more active signposts to services where appropriate.

Conclusion

The importance of faith and spirituality in mental health has been demonstrated and supported by numerous local and national reports and academic studies. In such an ethnically and spiritually diverse borough there remains a neglected opportunity to engage with local faith leaders and faith workers as key figures in the mental health care pathway. They can and do raise awareness of mental health problems, of the breadth of services available, support people living in the community and deliver non-medical sources of treatment which promote recovery.

Redbridge Concern for Mental Health and the Redbridge Faith Forum therefore resolved, with the support of the London Borough of Redbridge, to work closely with a selection of enthusiastic and committed faith workers to outline their views and priorities on mental health, and to provide evidence of the genuine need and desire for mental health training for faith groups.

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"We should look at how to integrate the mental health services with the spiritual aspect. We can give the real mental support. We need to look at the preventative side. We need to educate the young community to prevent the mental health problems. All of us can contribute a lot."

Focus group participant

Method

Focus Groups

Six focus groups were organised on Tuesday evenings in November and December 2008 for approximately two hours at each of six different local faith venues or places of worship. These were:

- Buddhist Centre (with Zoroastrian faith)
- Christian Church
- Hindu Temple
- Synagogue
- Muslim Centre
- Sikh Temple

Focus groups were selected as a method to yield as rich a narrative as possible and to encourage different members of each faith community to discuss issues and debate their views and this worked very well.

In the first focus group, notes of people's views were taken on flip chart paper but this was considered too slow, since the participants were so enthusiastic that the person transcribing felt that she could not capture all of the detail. For the remaining 5 groups, detailed notes were taken of each discussion by a person, typing on a laptop. With greater funds and more time the discussions would have been tape-recorded and transcribed but it was considered too labour intensive for this project.

Each participant read an information sheet (see 7.1: Appendix 2) to acknowledge their participation and each participant had a draft of this report emailed or posted to them (where they chose to give their contact details) and had the opportunity to make changes, to ensure that their views were recorded accurately.

Each group began with a five-minute presentation with music of a set of slides about mental health in Redbridge, using statistics about prevalence, numbers of people in work and the role of stigma (see 7.2: Appendix 3). This introduced the topic to the participants and gave them something to begin discussing. This worked very well and usually after about five minutes the discussion moved on to broader topics relating to spirituality and mental health. Key questions facilitators asked related to mental health in their community, how people would seek help and the role of faith in recovery.

At each focus group, two facilitators were present to draw out some of the views participants were expressing or to ask them to clarify things, as well as the person transcribing the discussions. In addition, at the Hindu, Muslim and Sikh discussions a facilitator attended who spoke Punjabi and Urdu/Hindi to ensure that any participants who would prefer to speak in those languages could do so. In such cases she listened to their comments and translated them for the benefit of the rest of the group and the typist.

Areas focused on

Facilitators kept these issues in mind during the focus groups, but in practice the dialogue flowed freely and naturally on the subject with little need for facilitation.

- What is your understanding of mental health?
- Would you welcome more professional support?
- What barriers are there to using mainstream psychiatric services?
- What problems are there in recognising and dealing with mental health issues in this community?
- What part does religion play in mental health and illness?
- What is your attitude towards mainstream mental health services?
- What help do people with mental distress generally seek and how readily

available is it?

- Are there issues around sign-posting people to statutory services?

Participants

In total, 62 members of different faith communities took part in focus groups for this project, of whom 51 were male and 11 were female. It was not considered necessary or appropriate to document participants' exact ages but most were in their forties and fifties bar several aged in their twenties in the Sikh group. The numbers in each group ranged from four in the Jewish group to 23 in the Muslim group.

Participants included Redbridge Faith Forum trustees, the clergy of the different faiths (including rabbis, Christian ministers, Buddhist monks and Imams), representatives of faith based counselling organisations and lay people and trustees of faith communities. Participants were invited to attend each of the groups by members of the Redbridge Faith Forum and faith workers involved at each of the religious centres or places of worship.

Limitations

Unfortunately the participants who attended were not balanced in terms of gender. This may well have been because of the timing of the focus groups or there may be a gender imbalance among faith leaders and faith workers such as volunteers. This limitation has meant that there is likely to be some bias in terms of the problems identified. For example, it was only a woman who commented that forced marriage was a mental health issue or that women's depression is often silent.

This weakness has been taken into account and with more time and resources we would have held a separate group at a different time for women of particular faiths. This issue must be taken into account when organising training sessions in future.

One limitation of focus group methodology is that it is a public forum, which may stop people from expressing views of which they are embarrassed or which they think may conflict with the views of others. In practice, there was a healthy level of debate in each group and people seemed to feel very free to challenge each other's views. In one group however, there was a sense that some participants wished to defend their community and to counter any suggestions that stigma might be prevalent.

We did not have the capacity to recruit a sample of participants, which was perfectly representative of the Redbridge faith community. It is therefore likely that this report does not express everyone's views on this subject. However, it is still considered a valuable starting point to gauge the level of interest in and need for mental health education, information and awareness training among faith groups.

Strengths

On the whole the focus group method was very successful and enabled different groups of faith workers to candidly express their views on mental health in their community. Despite acknowledging high levels of fear and stigma, many people were very open and honest about their thoughts and experiences.

Participants all showed a lot of enthusiasm for future training sessions about mental health and it was encouraging to find so much commitment to supporting vulnerable people in the community. The focus group method enabled us to sample the views of a relatively large number of people with a modest budget and in a short space of time.

> **"Older people can't get out and about. Language makes it very hard. They rely on the children. The children do not have time, do not spend time with them. "We work all day." It is like prison here for older people."**
>
> Focus group participant

Themes from Focus Groups and Conclusions

Theme 1:
Faith groups as Front Line mental health services

Each focus group of representatives of the range of faith communities in Redbridge acknowledged the pivotal role faith communities have to play in supporting the mental health of local people. Their role was clearly separated into two: one benefit being the social aspect of faith: belonging to a community and supporting one another.

- *Most people need a friend: someone to talk to. We have elders and pastoral care workers. The basic need for friendship is a start: that's what the Christian community is about giving. Vulnerable people who need comfort will come to the church.*

- *We have a network of supporters. We have a tradition [in Buddhism] of looking after the elderly, the unwell and when people are bereaved. We alleviate some of the primary things that lead to depression.*

- *There is a phase of depression where faith communities are very important. We speak in English but we do not all think in English.*

  People come to me. I can give them some advice from Buddhism so they can free their mind. We can discuss family problems.

- *Come in the temple and pray to God. Come to temple, explain to the priest. Get some sort of relief from the anxiety. He comes and talks and gets some sort of relief. We give him some advice. Some sort of help and solace from the community.*

- *They come because they feel comfortable in and want a Jewish resource and I'm not statutory so I can be a link, a bit more approachable, we must meet where they feel safe and confidential… there is a real fear of being so-called 'found out'.*

- *The synagogue is about the one place people can go where they are comfortable, accepted and treated just like everybody else. Everyone knows they have a problem but they have a cup of tea and friends and people talk to them the way they don't in Sainsbury's… the religious community can be extremely supportive and we can give people that warmth and support.*

  But religion can at times be very pernicious, I've worked with people who've been very neglected by a very tightly knit faith group.

- *She is schizophrenic. When she comes here [Sikh temple] she is fine, she is included in the prayers. She will not be talked down to, she feels part of the group: part of the crow.*

  People come here and feel part of the congregation. We are all equal here.

Quite distinct were the specific mental health benefits conferred by religious faith itself:

- *If you don't have strong belief in prayer you don't have anything. I firmly believe that belief in prayer is what you need.*

  But young people can rely on prayer. It can stop people getting help if there is a family reliance on prayer.

- *In Buddhism what we believe everything is starting from the mind. I suffered from serious depression. I got through it with Buddhist practice. There is a huge area explaining how the mind is working: brooding leads to deeper and deeper depression. You need to break the cycle of this type of thinking; it's not easy. "I know this thought is in my mind." The mind is creating all these things. This is mindfulness in a nutshell. It can add a very valuable tool to your way of life. We speak to our monk for spiritual guidance.*

- *From the Zoroastrian faith we have certain prayers that we recite – I recite one particular*

one. There are prayers for assisting with different parts of the body but not for healing.

- *It is important to have faith in your God initially. No-one knows what will happen tomorrow.*

  I don't think faith in God is enough.

  I feel faith is important. [When I was depressed] I believed in God, prayed to god ten times more. I think it helped a lot.

  Think more about your illness and God. God will make you know. It gives me hope. I did yoga. Mantra *does help.*

- *You would go to a masjid [mosque].*

  As an Imam, so many people come to me, especially jobless and with financial problems. They are really depressed and we advise them to pray. We try to help them with readings from the Qur'an. We advise them to be patient.

  Reading passages to clients from the Qur'an has helped, I believe, deter suicides and self-harm.

  Had they not been a Muslim, some of the people I have seen are convinced that they would have taken their life.

- *We had a qualified doctor. He was suffering from depression. He found his answers thorough* dhikr *[saying of a devotional invocation], through spiritual uplifting.*

  You get a tasbih *[a form of* dhikr *that involves the repetitive utterances of short sentences glorifying God] and you pray and there is a technique for this.*

- *Yes, a lot of people use faith, religion to help with emotional distress.*

  In the Sikh religion, Karma: what is happening due to your past life? It is meant to happen.

Several people talked about instances when as faith leaders or workers, they had to help people suffering from a mental health crisis. They provided important interventions but all acknowledged that they felt out of their depth and were unsure of how to best support the person. For example,

- *One chap ran away from Goodmayes [Hospital] and came here to the temple. We gave him food. "You can sleep here, we can give you blankets." We wanted to help him. But he pulled a knife. For two to three days he was calm and quiet. He appreciated the help.*

Many faith leaders discussed providing organised support to individuals and families suffering from mental health problems, of a similar form to that provided by care co-ordinators in the mental health service:

- *Someone who was bipolar wanted something to occupy her, she has some skills, is using them, realises she can make a positive contribution. I see her each week, we have a little session where she tells me what's happening to her and she feels that she can contribute. Those statistics that said only 24% [of people with a mental health problem] are in work and only 40% of employers would employ someone, that's surely going to be a major task for us to find voluntary work.*

  The family becomes very close-knit, sometimes you can't separate the family from the person, you have to work very holistically… We fit in very beautifully for the community, we work with the whole family. We are very much aware of… how the label of mental illness on one person affects everybody.

Conclusion 1

Faith communities provide significant social support to people suffering from mental health problems. Spirituality plays a crucial role for many people experiencing distress in their lives. Furthermore, spiritual practices from prayer to yoga and meditation provide comfort and a focus for recovery. Religion provides sense of belonging, hope, sense of

control and coping mechanisms, all of which are fundamental to good mental health. Faith workers are at times put in a position in which they must play a role in emergency care of a person in crisis and often take on informal roles as counsellors.

Theme 2: Stigma and Shame surrounding Mental Health problems

All of the faith groups talked about the role stigma and shame have to play in preventing people from seeking help for mental health problems. For some groups there was a strong sense that they would conceal their problems from the faith community but for others they saw their place of worship or faith leader as a more approachable, understanding alternative to statutory services.

- *The Church's attitude to mental health is very varied. Some people are very positive. Others suggest that as a Christian you shouldn't have depression. "If you pray you'll be alright"; some feel their faith should be enough.*

- *I would go somewhere anonymous because I've found it hard to raise difficult issues in the church.*

  Drop-ins in community venues wouldn't be attractive because people want to keep their problems a secret.

  The sense of guilt. Why should you go to the church? I feel bad enough about myself already. If you don't achieve the ideals we're encouraged to aspire to, you feel guilty.

- *Most people with mental health problems are helped very successfully in the church. I have often had to say "If you had a physical illness you would go to your doctor so why not go now?" There is stigma, feeling unaccepted. Not being able to talk is a barrier. They won't come out and talk. It's very difficult because basically you're ashamed of it.*

- *I remember my mother telling me in India that there is no such thing as recognising mental health. People who had mental health problems were put on massive ice slabs as treatment or given electric shock treatment.*

- *We have a stigma in Sri Lanka. Other people in the family suffer. If you break a hand you gladly show it. With the mind we do not recognise. It is an illness which can be treated, it is hidden. This comes from our society, our culture.*

- *Her friends over here one by one backed off and wouldn't help her. They couldn't deal with her. She would do some stupid things. Threaten to set the house on fire, run outside in her nightie.*

- *I know there is a member of a family who is not well. Because of the stigma they were afraid that if NHS or social services become aware it would lead to a section [under the Mental Health Act].*

- *My son is a doctor, I do not want to see anyone, or answer the telephone, just cry. My son said: "I will put you in the mental hospital if you carry on like this."*

- *I don't think our society is that encouraging. "He is a mental, he is a madman". Very few people listen.*

  Family will keep quiet. Do not want it to get out.

- *Some families will protect [their relatives] by keeping them away from society.*

- *In Redbridge people know people… they [people with mental health problems] feel very shunned and isolated from the community.*

- *The marriage prospects for the rest of the family plummet after a diagnosis of a mental health problem.*

- *In our community the prevalence of mental health problems is not usually obvious.*

What I found quite interesting [after watching a short film about mental health and stigma] is I discriminate and label people, which I should not be doing.

There is a negative image of mental health. A lot of people think it does not exist. I mean it is not spoken about. We need more awareness.

I never thought the percentage was this very high, we never hear about mental issues. We need to be made to be more aware of them. We need to address this in a mosque.

A lot of the time it will be kept hidden because it would be quite embarrassing for the family. It is kept under wraps, similar to drugs and alcohol.

Women's depression is hidden and silent.

I think people are ashamed to admit it to their community. People will not come and speak to the Imam about mental health problems, depression.

- *In the Asian community we don't talk about it… Ignorance, pride, fear of it – if you don't know what it is you are afraid of it.*

Great difficulty, finding people who will open up.

You might find the younger generation open up.

Nobody would approach a religious leader. Absolutely not.

If I've got it I don't want anyone to know it. I will hide it.

This selection of quotes really emphasises the battle faced by mental health services in seeming approachable and encouraging people to seek help early on. Mental health stigma is clearly found everywhere. However, faith communities with large numbers of people from ethnic minority groups showed their own specific sources of fear and shame, which would hold them back from opening up about mental health.

Conclusion 2

In faith communities, people feel guilt and shame for having mental health problems and some will not seek help there. Others feel more comfortable seeking help from their faith community and struggle to seek help from statutory services. Stigma and fear mean that people are misinformed about the nature of mental health services or feel unable to talk about mental health problems in the way that they can about physical health problems. Many people are surprised by how common mental ill-health is, because it is so infrequently talked about. This is likely to be the same for related problems such as substance misuse.

Theme 3:
The need for Mental Health Training

The groups we spoke to were unanimous in their agreement that there is a need for training for their faith groups in mental health awareness, particularly given how regularly they come into contact with people needing their help. They clearly felt that while training might start with faith leaders, other key individuals such as volunteers, well-known figures in the community and other important faith workers must have this training made available to them. They also discussed the need for greater education and information on mental health being made available to the wider community; this is discussed in the following section.

- *Our church has an over-60's club and one of our members is now in Goodmayes. I didn't see the symptoms of her needs so I need to be made aware of what to look out for and where to get help before they get to that point. I am happy recognising depression but with other problems I'm not so sure. One lady was telling me about increasingly bizarre things.*

- *There is alienation and separation. Who picks up on mental health problems? How do you recognise it?*

- *Ideally I would like churches to have a list of cards to refer people to a service with a sympathetic person at the other end. Do the different services ever get together instead of just communicating by telephone? Professionals need to know each other in the community. It brings wholeness and health. I would like for there to be mental health outreach to churches.*

- *I'm very keen to learn more about mental health symptoms. So many people in the congregation are suffering. I would like to have someone we could talk to about how to support them.*

- *I would like pointers to identify problems if they aren't talking to you about it, to aid recognition. I'd like to know possibilities of how you could help, links with agencies and having the information on paper. I would like support for carers and parents.*

- *[I did not realise] how quickly depression can become suicidal. There are also physical challenges, which people cannot see.*

- *The question we need to ask this seminar is how to empower faith leaders to signpost people. Where to? Faith leaders? Straight to Goodmayes? I wouldn't have a clue.*

- *How do you convince them that they need to be referred, in your own language?*

- *A respected person needs to deliver the message – for example the monk.*

- *The community should be hearing from someone who has been through the system.*

- *We should look at how to integrate the mental health services with the spiritual aspect. We can give the real mental support. We need to look at the preventative side. We need to educate the young community to prevent the mental health problems. All of us can contribute a lot.*

- *How can you tell [if someone has a mental health problem]?*

- *A huge area for me is young people. I referred a 24 year old yesterday, supposed bipolar disorder on a cocktail of medication; what can I really offer him? What is available in the community to not be institutionalised?*

- *A year down the line… the daughter has gone into a very depressed state. We should have realised sooner but we missed the daughter because we were so concerned with the dying mother. I think some form of very basic training so people could have some idea of what's going on with their friends and family that would be very beneficial. Like the basic training in adult protection.*

- *In all types of counselling, there is a number of people who come to you and talk to you to a point, but to persuade them to use any service, even marriage counselling, is another matter. We need ongoing training in how to break those barriers down… but we can never force people.*

- *We ought to have a meeting between all the rabbis to know what's there.*

  I wasn't aware of what's there.

- *Faith leaders are not well equipped or trained to deal with the issues. We need training for Imams and other leaders.*

- *We need training in the signs and the symptoms. If there is no information what will people do?The training should be in Punjabi [some nods from others].*

  Information. Leaflets I agree, training. People don't know much about mental health unless they are suffering. We need to know the first way of dealing with it until we get professional help. It should be easy to understand.

  We need more helpline numbers in community centres and gurdwaras.

  If you are equipped with the tools you can understand better what happened, what has

caused it.

We need stuff about drug abuse too.

Conclusion 3

Many faith workers were unsure how to recognise people needing help for mental health problems among their congregants and how to support them. They want to be more confident as to who they can refer people to and to better understand the services available so that they can encourage people to use them. They want training both from people from their own community and in some cases in their first language and from service users. They also asked for training that covers preventative measures to improve mental health at an early stage, particularly with young people and issues affecting them such as substance misuse.

Theme 4: The need for community Information and Education

The groups discussed a range of issues about which they felt they and their communities were misinformed or ill-informed. These included what services are available, what mental illnesses actually are and how they are manifested and how to navigate the mental health system.

Importantly then, the groups felt that whilst they themselves needed mental health training to support vulnerable people, they felt that all of their community would benefit from greater information and education on the subject of mental health.

- *Who is able to come if someone falls ill in the street? The police? In the Roger Sylvester case [in Haringey] the police didn't know what they were doing. In response, St Ann's hospital trained the police in mental health; is it done here? What would we do if we saw someone like that in the street? Probably walk by. It would be nice to be able to call the hospital for them.*

- *Depression sometimes does not have an outward sign. People say: "What are you talking about? You look all right." The first hurdle is that it is not visible.*

  People don't take it seriously that depression is an illness or problem.

  They say: "Why? You don't look physically different. You look all right. What is your problem?"

  It has not been given the same profile as cancer and heart disease.

  There has to be raising of awareness of this issue of mental health. All religions have strategies, which can help.

  In most of the Asian countries, we have just one or two words that refer to mental illness. In Asian languages we have one or two words.

  In Hindi- pagal, which translates as mad. I don't think that is correct. In Asian languages we have classified medical illnesses.

  There is no such thing as 'depression' in Bengali language.

  For someone to be labelled pagal there would have to be manifestly observable irrational behaviour. The stereotype is of people losing their minds, banging their heads against the walls.

- *Information should come through more approachable forums.*

  Before coming into this country I was living in Sri Lanka. We rarely talk about stress in Sri Lanka even in the medical fields.

- *I don't know if there are culture-specific things for Jewish people but in a lot of parents I encounter there's a lot of frustration and problems. They are exasperated, but afraid because once the child's labelled within the*

[mental health] system, one-way or another there's no way out.

- *The elderly I find, similarly, people not wanting to deal with. "My father in law's just had a brain scan for Alzheimer's; I don't think I want to hear it"; the fear.*

  People are so unaware.

  There's the wider group, not the immediate family, lacking in knowledge and awareness who could be so supportive to the whole family; maybe it's something that we could do.

- *The Muslim community lacks knowledge to deal with the problem.*

  There needs to be education, for example [there are] people who try to beat Jinn *[spirits] out of people.*

  Education is best to be given within the community.

Conclusion 4

The faith workers felt that training must include basic information and education, which they could then disseminate in their communities. They need to know what services are available, how to navigate them for themselves and loved ones and how well trained groups such as the Police are to understand mental ill-health. Their communities need to know more about the nature of mental health problems and for some ethnic minority groups for that to be explored in their first language. People need more information to reduce their levels of fear of mental health problems and treatments and they want it to be delivered in the community.

Theme 5:
The role of Faith Workers in Signposting

As already outlined, the six sets of faith representatives who participated in focus groups identified huge barriers of stigma and shame around mental health which hold faith communities back from seeking help and treatment sooner. All groups were keen to point out that they did not want to take the place of existing mental health services which are provided by trained professionals, but rather they felt that with training in the basics they would be better able to swiftly refer and signpost people to the most appropriate services to support them.

- *It is dangerous as a minister to think that you can help everybody. Friendship and spiritual guidance are fine but you need to refer to professionals. We can only do so much. It is common for clergy members themselves to break down and some of them now talk publicly about it. Ministers themselves burn out. Who do they go to? We now have designated professionals for them because they take on everybody's burdens.*

- *We are coming from developing countries where NHS organisations don't exist. There are other structures such as family but it is not a specialised structure, it cannot deal with everything.*

  I would signpost people to contemporary medicine.

  [Of a friend with a mental health problem] Her family in Bombay did not want her to go into hospital. That was quite scary. I wouldn't have signposted her to read our holy books. Offering religious solace was out of the question.

- *Our monk may be able to recognise when it is more than just spiritual guidance that is necessary; he can also refer to traditional ayurvedic practitioners.*

  Faith leaders need to be brave enough to say "I've done as much as I can; now you need to be seen by someone else." Faith leaders need to be supported by the PCT [Primary Care Trust] in developing that role.

  There should be some route from the NHS back to these communities.

- *We tend to work with Jewish Care, recognise that that's where the skills and expertise lie, or the GP. Jewish Care as wonderful as it is, doesn't have somebody there for everything. Then we will go direct to statutory services.*

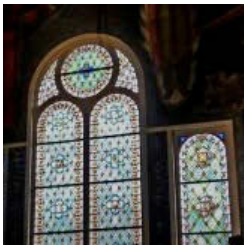
- *Imams can act as a referral to a practice professional – not to resolve but to support the issue.*

  [On] first impression the Imam will try to help with spiritual [needs, but you are] coming to an institute which cannot be equipped to deal with depression and anxiety.

  I think I agree, I think an Imam has an important role as a referrer and their role should be able to refer them to people who to contact.

Conclusion 5

Participants are very aware of the limits of support they as faith workers can provide. They identified a key role for themselves in providing support and understanding and referring congregants to statutory services, spiritual forms of solace where appropriate (including traditional forms of Medicine) and voluntary sector organisations. They want to know to whom and how to refer people quickly and efficiently without leaving them to be referred endlessly from one team to another.



Theme 6:
The role of belief in Spirits and Possession

Strongly held cultural beliefs in mental health problems as manifestations of possession, curses or spirits of some kind were discussed in depth by the group of Muslim faith representatives. However, these beliefs are not at all exclusive to that faith and are widely held by individuals of many religions, more commonly among ethnic minority groups. These beliefs are personal and deeply held, and are not necessarily incompatible with treatment by statutory mental health services. They must be taken seriously and local faith workers can play an important role in educating health professionals about these beliefs and informing communities about the benefits of seeking medical help.

- *My brother was suffering from anxiety; the first thing everyone said was that he was possessed. People need to be made aware that there is depression, anxiety and that it is not possession. It is not always Jinn [spirits].*

- *Our community lack a lot of knowledge when it comes to depression and anxiety. I always get told he is possessed. I took him to Pakistan and a private doctor, who understood our culture as well as the fact it was a medical problem cured him.*

- *Muslims talk about Jinn. It is hard to describe this to an atheist. Muslims want someone who understands their language and faith. The brain is receptive to this help.*

- *There are a lot of adverts in the local newspapers, which abuse vulnerable people by offering black magic, healing and so on. This needs to be highlighted: there is a big open door for abuse. People are so weak and have a small mental problem; this is when the Imam [must] make people aware of con artists.*

  Imam: We announce on regular occasions that these adverts are misleading.

- *The majority of Pakistani Muslims are liberal. 10 or 5 % are orthodox. But when it comes to mental illness they are 100% orthodox and believe it is Jinn.*

- *Jinn is used as an excuse, e.g. a girl is sexually abused by an uncle or grandfather and the abused will start wetting the bed, not sleeping. It will be blamed on Jinn rather than face up to the fact of abuse.*

Conclusion 6

Alternative beliefs about the cause of mental health problems are prevalent within ethnic minority faith communities in Redbridge and in some cases prevent people from seeking

help from statutory services. For this reason many of these people feel that only a member of their own faith or ethnic group will understand their needs. For this reason faith workers can play a pivotal role in supporting and encouraging people dealing with mental health problems to make the transition to using statutory services.

Theme 7: Services provided by Faith Groups

Members of the different faiths discussed the big and small efforts they have made to support the mental health of their communities or improve access to faith resources. These highlight the proactive nature of the faith sector and the amount of work that can be achieved with small financial resources but large numbers of enthusiastic volunteers. These efforts highlight the importance of better engagement of mental health services with community faith groups and more joint working.

- *Now at Our Lady of Lourdes the readings are translated into ten different languages. We now have very ethnically mixed congregations with growing diversity. It used to be a very strong Irish community and now there is a very big Polish group, which is catered for by a Polish order of priests at St. Cedd's.*

- *Church services hold people in a safe space, which is an enormous contribution. Most churches have several groups catering for different ages.*

  Clubs and groups help people get back their self esteem so maybe they won't need all the pills.

- *We used to have a CBT [Cognitive Behavioural Therapy] therapist. We're getting a consultant at Barnet Hospital to set up a [CBT] computer programme, which people are accessing. There are two groups where trained volunteers help people with bereavement and divorce serving the whole Redbridge Jewish Community; it's been running now for 21 years and I brought it to the faith forum to see about expanding it. It could be a model with training provided but no-one's taken us up on it. We've expanded geographically and moved into telephone counselling and that's worked very well… If Jewish communities are less likely to use mainstream services that may well be because there are other services that they can use provided by their own community.*

  When people are unwell the culture-specific things become much more important.

- *All of us receive training in identifying and referring mental health issues and some psychodynamic counselling. Comparing, other faith communities in the area may also want to set up similar schemes.*

- *Drugsline [a Jewish-established organisation] now has a partnership ['Joining the Loop'] with the Muslim community.*

  It has been very, very successful.

  You might ask, why the Muslims and not the Sikhs and Hindus? It might be extended to other faith groups in the area.

Conclusion 7

Faith communities are flexible and provide services in different languages, organise groups and clubs for different people and some faith organisations have the scope to provide their own therapy services. The experience of collaboration between different faiths working towards the same goal is evidence of the creativity and enthusiasm within the faith sector, which remains under utilised by mental health services.

Theme 8: Partnership between Faith groups and Health services

An extension of the work that is currently being done, many of the groups want to develop partnership working with specific mental health teams or social services but either do not know how to begin or have not had much success. Development of mental health training for faith groups in collaboration with the statutory sector could be the beginnings of this sort of link working.

- *It's not easy to set up collaboration services between Health and the Church.*

- *Imam: During my 5 years' period here I've never been approached by a health professional.*

  There is lack of communication. We have been here since 1978 not a single approach by health services or a professional organisation.

- *You need to cater for that community by employing Imams. Patients bring their children or friends to interpret and the children are too embarrassed to translate correctly, or do not translate correctly.*

  There is an important role of a Muslim priest to be working with health workers. We do have fear, we have depression needs too.

- *Some of us who are Muslim think that the Western medical model is not appropriate in terms of categorisation of illnesses and it needs to be more holistic.*

Importantly, it was suggested that the Muslim community could take a role in training healthcare workers in basic and relevant aspects of Islam, for example assisting with North East London (Mental Health) NHS Trust's cultural competence training for all staff.

Conclusion 8

Faith workers feel strongly that there is scope for joint working between them and statutory mental health services but have struggled to establish links and contacts. There is an important role for faith groups in training mental health workers in cultural and spiritual awareness and understanding but also for mental health workers in training the faith sector.

Theme 9: Culturally Sensitive Services

In support of the need for greater partnership working between mental health services and faith communities, several groups talked about the need for statutory provision to be more culturally sensitive in order to be effective and to engage, particularly, with ethnic minority groups. A number of people felt that they could only open up to someone from their own community. For these people, faith workers from the same community can be an imperative link with mental health workers who may or may not be from the same background. They can also be vital in raising awareness of the services available in the statutory sector, such as interpreters.

- *I don't think we can separate mental and spiritual health. Many people come to me because they want to see someone who is a (religious) Muslim and a trained psychotherapist.*

- *My wife is a dietician and has a client who is overweight. She has left her home country is comfort eating and feels she needs to… speak to someone who is from the same culture.*

- *Because of his belief and his culture the doctor he didn't understand because the doctor wasn't from the same background.*

- *If an Imam talks to me, he knows I am Muslim. He will use the angle that a known Mus-*

lim would. When it comes to mental health, you need to deal with a person from your faith.

But you don't start insisting in people from your community, it depends.

Muslim almost exclusively wants a Muslim professional… Muslim will use Jinn, black magic and people find it quite difficult to relate to an atheist.

There are a lot of open minded professionals.

- *My father wouldn't take the help because he didn't like the look of him [health professional]. What made the difference was talking, speaking the same language. He started by talking about back home.*

Conclusion 9

Some participants felt that only mental health professionals from their own cultural or spiritual background can understand their needs. This implicates an important intermediary role for faith workers, who are approachable, to gradually refer people on to statutory services by explaining how the system works and raising awareness of accessibility, for example, the widespread use of interpreters.

Theme 10: Specific Challenges for the Community and Faith Leaders

Faith workers discussed some of the specific challenges they and their communities face. These will be important to consider when tailoring mental health training programmes to individual populations with their own specific needs.

- *Mental illness caused by the pressure of modern society. The elderly cannot keep pace with the society and what is happening.*

  Modern life is so much pressure – you will not find many mentally disordered in a small village in the country. There is a hell of a lot of pressure from the work, the telly, see the advertisements on the TV. People are hooked. Put together do get mentally [ill].

  No-one is satisfied any more.

  It's not so bad in India because there is not so much pressure.

- *I get called by non-members because we are such a large synagogue. We don't have a huge number of staff and two of us don't live locally. Occasionally hospitals will call us. There are 17,000 Jewish people in the borough and they're getting lost.*

- *It depends on what age group. Family problems, education, jobs.*

- *Forced marriage is a big issue. You are expected to marry a Sikh. Your daughter in law is expected to have sons, it can create anxiety.*

  That is changing.

- *With Asian people there is comparison: "If he has got it I want it too. If he has a bigger house, I want a bigger house. I want to be one better than you". Jealousy, envy.*

  You should be happy with what you have.

- *Some elderly people at home suffer from loneliness. Stay indoors.*

  Older people don't understand nurses (language problem), what is going on in hospitals. The young children do not have the time to visit. They are working.

  Older people can't get out and about. Language makes it very hard. They rely on the children. The children do not have time, do not spend time with them. "We work all day." It is like prison here for older people.

- *We worry more about the children, worry constantly, especially with the stabbings, worry about the streets. Are they safe in the schools?*

- *Abuse of alcohol, drugs and violence in my opinion has increased. You see 20 people by the Fitness First gym, sleeping, drinking.*

  Lots of people are homeless.

- *People don't have time for one another. If you make time for them you can help them. I know someone who is 18 who has depression. It becomes very hard to take the person away from a 'bad' environment if the in-group who is taking alcohol and drugs.*

Conclusion 10

Different faith workers identified a range of challenges facing themselves and their congregants. These included the pressures of modern life, both for the working generation and the elderly, family problems, forced marriage, comparison with others, loneliness and isolation, language difficulties, worry about children's safety and substance misuse. For faith workers there is also the challenge of serving a very large population and having limited resources with which to support them.

Theme 11: Should training be delivered to separate faith groups?

Finally, some groups discussed whether they would prefer to receive mental health training in faith-specific groups or mixed ones. In general there was some consensus that there would be benefits to receiving training within a group of one's own faith community but that there should be some opportunity for the different faith groups to share what they had learned and to encourage more partnership between the faiths.

- *I think there is a real benefit for bringing all the communities together so people understand that we're all in the same boat, there's something overall that we could talk about in terms of stigma, that's going to be right across the board I would imagine. Plus we have in common the things we will want local authorities to be providing.*

  Some kind of half-day conference where we share our results with the community and service providers.

Conclusion 11

There are real benefits, demonstrated by the success of the focus groups, for delivering some mental health training sessions in faith-specific groups. However, an event, which brings together all the relevant stakeholders to share what has been learnt and encourage future collaboration would be very valuable.

Finally

This report clearly demonstrates the genuine enthusiasm for, interest in and need for mental health training in the faith sector in Redbridge. It highlights the significant role already played by faith communities in promoting one another's mental health and the very real scope for expansion of partnership work and development of explicit care pathways between faith organisations and mental health services. It is suggested that a well-tested model such as Mental Health First Aid training be explored as a pilot but for there to be room for the training to be more specifically tailored to the needs of the individual faith groups. This presents a simple, cost-effective and valuable opportunity to make real steps towards delivering genuine equality in mental healthcare, not just for ethnic minority groups, but for all.

"I'm very keen to learn more about mental health symptoms. So many people in the congregation are suffering. I would like to have someone we could talk to about how to support them."

Focus group participant

Recommendations

1. Redbridge Faith Forum (RFF) working in partnership with Redbridge Concern for Mental Health (RCMH), Anxiety Care, Redbridge Equalities and Communities Council (RECC) and Redbridge CVS (RCVS) should plan a mental heath training programme in spring 2009. This should be delivered to faith leaders and other faith workers from the different religious and spiritual groups represented in the Redbridge population during 2009/10. This training should aim to develop the capabilities of faith leaders and faith workers in understanding mental health problems and the needs of their community. The planning should include working out the number and duration of training sessions and what trainers/ facilitators would be needed.

   Once available funding is established, a working party should be set up to help plan the training courses, to include RFF, RCMH, RCVS, Anxiety Care and RECC, with representatives of North East London NHS Foundation Trust (NELFT), interested faith leaders and people involved in similar training in other local boroughs, such as Newham.

2. Designated local workers in Redbridge should be trained on a Mental Health First Aid training course as run by the National Institute for Mental Health (see 7.0: Appendix 1) in spring 2009. This course could provide the template for the training which they would deliver to faith community leaders in Redbridge.

   However, an important question for the working group recommended in 1. would be whether Mental Health First Aid is the most appropriate form of training for faith communities and whether it allows sufficient flexibility to address the culture-specific concerns identified in this report.

3. Important topics to be covered by the training could be:

   - Key mental health problems and how they can manifest themselves.
   - What to do when helping a person suffering from a mental health crisis.
   - Information about the prevalence of mental health problems in the community.
   - Clear outlines of how mental health services work and how they can be accessed, including the opportunity to hear from mental health service users and mental health practitioners. Where possible and appropriate, these individuals should be members of the faith community in question.
   - How to know when a person needs to receive professional help and when to refer them to statutory services.
   - How to tackle stigma and discrimination in the community.
   - Specific information about reliable ways to refer a person to mental health services.
   - Discussion of how to help a person to use statutory services when they feel only someone of their culture will understand them.
   - Advice on working with young people and positive preventative measures.
   - Discussion of ways to increase knowledge and understanding about mental health problems within the community.
   - Where appropriate, discussion of how to reconcile belief in spiritual possession with seeking medical treatment for mental health problems.
   - Acknowledgement of the challenges faith workers will face and ways for them to cope with the distressing things they may experience in supporting their community.

4. In designing this training programme there should be opportunities for mental health practitioners to interact with the faith communities, to encourage partnership working and sharing of skills. At the higher management level of the North East London NHS Foundation Trust, the Local Implementation Team and the Redbridge Primary Care Trust it must be explored how best to establish direct care pathways from key faith leaders to Community Mental Health Teams.

5. After the training sessions have been delivered (subject to appropriate funding) there should be an event, which brings together all key stakeholders from the faith and statutory sectors, to share what has been learnt and to evaluate the training. After a period of three months all participants should be surveyed to determine what benefits the training has had.

6. If considered effective, the training should be rolled out to additional groups of faith workers and a 'train the trainers' programme, which enables the community to be in charge of spreading awareness, should be explored.

7. Redbridge Faith Forum should organise a public forum on mental health issues in spring 2009 to discuss the issues arising from this report.

Appendix

Appendix 1: Mental Health First Aid Information

Retrieved on 08/02/2009 from:
http://www.mentalhealthfirstaid.csip.org.uk/silo/files/national-evaluation-summary.pdf

What is Mental Health First Aid?

There is widespread ignorance of mental health issues in the general population and there is stigma associated with them. This stigma in turn can lead to delays in people seeking help. There is also a lack of confidence in what to do if someone is distressed or in a crisis situation. Mental Health First Aid (MHFA) was developed in Australia in 2000 by Betty Kitchener and Professor Tony Jorm as a response to this with the aim of improving mental health literacy of members of the Australian community with the philosophy that mental health crises, such as suicidal and self harming actions, may be avoided through early intervention.

The aim of all first aid is to preserve life and promote recovery. First aid for physical injuries teaches people how to give initial care until medical treatment is accessed. The aims of MHFA are similar but, in teaching people how to give initial care, the course also aims to dispel the fears people often have when they come across someone who they suspect has a mental health problem or is in distress. Learners practice listening skills and think about how to assess for self-harm and suicide. The emphasis is on providing comfort and signposting to further help.

The course is delivered in four modules and takes 12 hours to complete. The modules explore depression, anxiety, suicide and psychosis. The MHFA instructors course requires completion of the 12-hour course, then an additional competency-based five-day course (ie seven days in total).

The programme has been extensively evaluated in Australia including two randomized controlled trials. All studies have shown statistically significant benefits 5-6 months post training in helping behaviour, confidence in providing help to others, decreased social distance from people with mental health problems and improved concordance with health professionals about treatments.[1] One trial carried out in the workplace found positive effects on participants own mental health.[2]

The course has changed my perspective of people with mental health problems. It makes you aware that we can all get mental health problems at some stages in life, to varying degrees.

Mental health – Confidence and Competence

MHFA training provides the two 'Cs' – confidence and competence. The competence to be able to spot the signs and symptoms and guide that person to appropriate help, as well as the confidence to know what to say and how to say it. This is done through exploring our own perceptions of mental health and mental illness and establishing that these are very different things. The training helps participants to identify the symptoms of common experiences such as depression, anxiety and psychosis.

Appendix 2: Information Sheet

Mental Health Focus Groups Information Sheet

Introduction

Redbridge Faith Forum has obtained a small grant from the London Borough of Redbridge to conduct a series of seminars, workshops and training sessions for faith leaders on mental health issues.

Background

Research indicates that religious communities and individuals are reluctant to use mainstream psychiatric services. The literature also suggests that religious leaders are overwhelmed with pastoral and counselling work and that they would welcome more professional support and they do and would refer for professional help.

What are the aims of the focus group?

1. To find out the views, opinions and experiences of faith leaders and congregants with regards to mental illness and mental health.
2. To find out the needs of faith leaders with regards to mental health training
3. To engage with faith communities in order to capture their understanding of the challenges they face; and the actions that would help in overcoming them.
4. To use the information and ideas to design a mental health training programme

What will happen to the results of the focus groups?

A report will be written up and presented to the Redbridge Mental Health Partnership Planning Group Redbridge NSF Local Implementation Team (LIT) and will be used to plan and deliver a mental health training course.

Remit of the LIT: The LIT provides strategic direction and is responsible for overseeing services for adults with mental illness. The LIT ensure that services are commissioned, delivered, monitored and evaluated through an effective partnership of all relevant agencies. It ensures that the National Service Framework for Mental Health is implemented in the London Borough of Redbridge according to Government guidelines.

How will your privacy be protected?

Every effort will be taken to protect your identity as a participant in this study. You will not be identified in any report or its results.

Appendix 3: Statistics from the 'Mental Health in Redbridge' presentation

- There is no health without mental health.
- At any one time, one adult in six suffers from a mental health problem.
- Over 30,000 men and women in Redbridge.

Older People

- Approximately 1 person in 50 aged between 65 and 70 has dementia.
- 60% of acute hospital inpatients over 65 years of age will have a mental health problem.
- Significant depression is present in 15% of older people.

Children and Young People

- In Redbridge there are over 32,000 children between the ages of 5 and 14.
- Over 3000 of them are likely to have a mental health problem.
- In young people depression and low self esteem are linked with smoking, binge drinking, eating disorders and unsafe sex.
- Suicide is still the biggest cause of death in young men.

Depression and Anxiety

- It is suggested that more than half of those who attend their GP may have some symptom of depression.
- 60 to 70% of adults will at some time in their lives experience depression or worry of sufficient severity to influence their daily activities.
- By 2020 depression will be only second to chronic heart disease as an international health burden.
- Strong evidence establishes depression as a risk factor for heart disease.
- One in 10 people are likely to suffer from disabling anxiety at some stage in their life.

Some Facts

- It is estimated that nearly 3 in every 10 employees will experience a mental health problem in any one year.
- According to the Royal College of Psychiatry: 1 in 5 people recover completely.
- Only 24% of adults with long term mental health problems are in work.
- Only 40% of employers say they would employ someone with a mental illness.
- Research shows that many of us learn about mental illness through the media.

Stigma and Discrimination

- The Sun: "Bonkers Bruno locked Up."
- The Daily Mail: "Knife maniac freed to kill. Mental Patient ran amok in the Park."
- The Sun: "Violent, Mad. So Docs set him Free."