JewishCare
Enriching Lives

2 July 2019

Royal Commission into Victoria's Mental Health System
PO Box 12079
A'Beckett Street
VICTORIA 8006

To Whom It May Concern

Jewish Care Victoria Submission – Royal Commission into Mental Health

Please find attached Jewish Care Victoria's submission to the Royal Commission into Victoria's Mental Health System.

Jewish Care welcomes the opportunity to make a submission to the Commission and would also welcome the opportunity to contribute to future discussions to further clarify the needs of the Jewish community, or in relation to any policy or funding considerations in the area of mental health.

Our submission is informed by Jewish Care's work with people who are affected by mental ill health, our research piece *The Mental Health Needs of the Victorian Jewish Community*, and the services we provide to the ultra-Orthodox Jewish community.

Yours sincerely

Bill Appleby
Chief Executive Officer
Jewish Care (Victoria) Inc.

דרך ארץ
derech eretz
respect

קהילה
kehilla
community

הכללה
hachlala
inclusion

אחריות חברתית
achrayoot chevratit
social responsibility

Jewish Care (Victoria) Inc
619 St Kilda Road
Melbourne Victoria 3004

PO Box 6156
Melbourne Victoria 3004

Head Office: (03) 8517 5777
All Services: (03) 8517 5999
info@jewishcare.org.au
www.jewishcare.org.au

ABN 78 345 431 247
ARN A0040705X

Jewish Care Victoria is the leading community support organisation for the Victorian Jewish community. A pioneering organisation with a long history of influence, Jewish Care was first established in 1848 as the Melbourne Jewish Philanthropic Society and today is a large, thriving organisation responsive to the changing needs of the Jewish community of Victoria. Jewish Care has over 700 staff and 300 volunteers. Its foundation values of respect, community, inclusion and social responsibility underpin a clear vision and mission to support and enhance the wellbeing of the Jewish community of Victoria by offering a breadth of programs for individuals and families.

In addition to a range of aged care and disability services, Jewish Care's Individual and Family Services division, funded by the community, works with the most vulnerable members of the community through the following services:

- Information and Access service
- Complex Care – Service Coordination program
- Housing Support
- Financial Counselling
- Emergency Aid
- Youth Mentoring
- Employment Services
- Health Promotion.

Jewish Care welcomes the opportunity to make a submission to the Victorian Royal Commission into Mental Health. We would also welcome the opportunity to contribute to future discussions that seek to provide further clarity about the needs of the Jewish community or in relation to any policy or funding considerations in the area of mental health.

This submission is informed by Jewish Care's work with individuals and families who are affected by mental ill health, including the aged community; our

research piece *The Mental Health Needs of the Victorian Jewish Community;* and the services we provide to the ultra-Orthodox Jewish community.

The submission is divided into three sections.

Firstly, it outlines the need for culturally-safe service provision, with a focus on the needs of the ultra-Orthodox community who commonly experience a range of barriers that can impede access to mainstream mental health services. The second section highlights the need to ensure that mental health promotion and capacity-building endeavours for culturally diverse and faith-based communities such as the Jewish community are relevant, accessible and impactful. The third section highlights the need for improved access to non-acute mental health services for the aged community, particularly those living in residential aged care.

Section 1 – The need for culturally safe service provision for the Jewish community.

The Victorian Jewish community consists of some 52,000 people. Its fabric is woven from peoples from around the world including Israel, South America, Eastern Europe and South Africa alongside those who have lived in Australia for multiple generations. How Judaism is expressed is as diverse as the languages spoken.

There is a unique pocket of the Jewish community who are generally much less responsive to and less impacted by the mainstream. These are the families of the ultra-Orthodox communities, who ascribe to deeply religious values and are typically highly insular. It is estimated that some 4500 of the Victorian Jewish community identify themselves as ultra-Orthodox including 2000 from the Adass community[1].

[1] https://www.jca.org.au/wp-content/uploads/2018/03/Gen17-Initial-Findings-report-ONLINE-final-22March2018.compressed.pdf

The presumption that the Jewish community is well-integrated and socioeconomically privileged belies its true status as a highly diverse community with a range of cultural and religious needs. Jewish Care recognises that the specific religious and cultural traditions of the Jewish community have at times created hurdles to the effective prevention, identification and support of individuals and families affected by mental ill health. The major factors contributing to such barriers include:

- The small and extremely close-knit nature of the community, which heightens concern around the impact of disclosure on social exclusion and status;
- The impact of traditional Eastern European conceptualisations of mental ill health which typically do not identify mental illness as a legitimate experience;
- A tradition which preferences help-seeking from community leaders such as Rabbis, who may not have appropriate or up to date knowledge and skills, rather than a secular health professional;
- A strong emphasis on keeping individual problems such as mental ill health within the family so as to avoid bringing shame on the family or community;
- Perceived distrust of secular services; and
- The impact of mental ill health on marriage prospects in the religious community. Marriage in this community is typically by arrangement and concerns regarding the impact of a perceived slight in the family's history or standing on marriageability are commonplace.

While the above factors refer specifically to the challenges and experiences of the Jewish community, the influence of stigma is replicated in many other culturally diverse and faith-based communities. There are factors common within the Jewish community which also influence service delivery and highlight the importance of cultural safety in service provision - these include the experience of intergenerational trauma and the role and engagement of extended family in service provision.

As per the broader community, the experience of mental ill health can impact on a variety of life domains, and can convey particular barriers with respect to service engagement. This is further complicated for people from culturally and linguistically diverse and faith-based communities. With more than half of Jewish Care's Service Coordination (complex care) clients identifying mental ill health as either a significant concern or the primary reason for contact, it is clear that ethnospecific services also fulfil an important role as 'soft' entry points to mainstream mental health services. People with mental illness are over-represented in other Individual and Family Services programs, including employment, housing and financial counselling.

Provision of appropriate service to the Jewish community should consider the need for assertive outreach to engage community members who are reluctant or afraid to disclose; the importance of trauma-informed and culturally-safe service provision; a planned approach to engagement for hard-to-reach communities; and an approach that is sensitive and responsive to the collectivist, family-centric nature of the community.

Section 2 – The importance of tailored and community-led health promotion for culturally diverse and faith-based communities.

Mainstream health promotion endeavours including social campaigns, promotional materials and educational sessions are generally less impactful when implemented within culturally and linguistically diverse settings, including the Jewish community.

Research has consistently shown that the use of a consumer-led, 'in-community-out' approach to the development of health promotion resources

enhances their efficacy in culturally and linguistically diverse communities.[2] Though stigma around mental ill health is, unfortunately, commonplace across Australia as a whole, there are particular cultural, social and religious drivers within the Jewish community that influence the nature and impacts of mental health stigma.

To effectively challenge these unique drivers requires a tailored, ethno-specific approach that:

- Is cognisant of the influence that cultural, religious, and spiritual factors have on mental health literacy for the target community;
- Is responsive to the impacts of experiences that increase vulnerability to mental ill health – for instance, the experience of racism and exclusion, and how this can impact on an individual's sense of belonging;
- Identifies gaps in knowledge for that particular community, and targets capacity-building activities around these;
- Utilises and reflects the values, norms and iconography of the target community;
- Eliminates barriers to resource uptake as much as possible – for example, the ultra-Orthodox community are generally not able to use or view promotional materials that depict photographs;
- Is available in community languages;
- Is distributed through pathways, mediums and sites that are relevant for the target community - for instance, the ultra-Orthodox community typically does not access secular television, internet, newspapers or books; and
- Draws upon the influence of respected community leaders to enhance buy-in, confidence and impact.

[2] The Ottawa Charter for Health Promotion.
https://www.who.int/healthpromotion/conferences/previous/ottawa/en/

Previous mental health promotion campaigns developed specifically for the Jewish community and led by Jewish Care, including the *Postcards for Pesach* resource, *Reach Out Speak Out* campaign, *Raising Healthy Families* parenting program and *Mental Health for Madrichim* training, have utilised the above strategies to great effect.

By their very nature, mainstream resources are inherently generalist and therefore unable to reflect the norms and values of diverse or minority communities, which significantly limits their efficacy and impact. Community organisations are ideally placed to draw upon relevant narratives and imagery, and utilise existing communal networks, pathways and information mediums to enhance distribution and uptake. It is the view of Jewish Care that mental health promotion and primary prevention endeavours must utilise a cultural lens in order to be effective in culturally diverse, minority and faith-based communities; communal organisations should be adequately resourced to develop tailored, ethno-specific materials that are appropriate and impactful for their communities.

Section 3 – The need for a robust mental health service response for older people, particularly those living in residential aged care.

The experience of ageing and the transition to supported accommodation often presents a significant challenge to the mental health and wellbeing of older people. The ageing experience of individuals who are from culturally and linguistically diverse backgrounds or who have a lived experience of trauma adds further complexity. Despite the increased prevalence of mental ill health in this cohort – an estimated 52% of elders living in residential aged care experience depression[3] – the service response for older individuals, particularly in non-acute settings, has historically proved inadequate. Prevalence in culturally and linguistically diverse elders is higher again.

[3] Australian Institute of Health and Welfare. (2013). *Depression in residential aged care: 2008-2012.*

It is the view of Jewish Care that despite the best efforts of previous governments, the mental health service system as it currently stands is both fragmented and inadequately resourced, with a significant gap for older community members who live in residential aged care and are ineligible to receive psychological support via Medicare under the Better Access scheme.

Jewish Care's experience has been that the service response for older people from Primary Health Networks has been insufficient, and despite its expressly stated priority of supporting individuals living in residential aged care, has proved extremely difficult to access.

To date mental health services for the over-65 cohort have been focused primarily on provision of acute support via mobile assessment team and inpatient support which, while undoubtedly important, neglects to support the broader mental health needs of older people. A specialised response to the needs of this cohort should be tailored to and considerate of the particular vulnerabilities or precipitating factors commonly experienced by elders, such as the transition to supported care; the experience of grief and loss; end-of-life challenges; spiritual crises; and physical ill health.

An effective service response must also prioritise the needs of diverse communities; for instance, the availability of practitioners who can provide in-language services and are cognisant of the impact of stigma and the barriers it can present to effective help-seeking and therapeutic engagement for the aged community. Furthermore, for members of the Jewish community who are Holocaust survivors, the experience of trauma that often re-emerges with ageing, particularly where there is co-morbid dementia, warrants specialised and robust support.

JewishCare
Enriching Lives

Summary and Conclusion

In order to ensure opportunities for equitable access to mental health information, promotion/prevention activities and service provision for all Victorians, Jewish Care makes the following key recommendations:

RECOMMENDATION 1: That the Royal Commission recognises that ethno-specific services have more than a peripheral role to play in the promotion, prevention and early intervention of mental health activities and must be resourced adequately to meet the needs of their specific communities.

RECOMMENDATION 2: That the Royal Commission recognises that the needs of minority religions differ from culturally or linguistically diverse communities and require an approach that actively engages ethno-specific agencies in planning and implementation.

RECOMMENDATION 3: That the Royal Commission recognises that local planning for mental health responses from promotion to intervention must include the active engagement of ethno-specific services within that specific area to ensure relevance and equity of access and resource.

RECOMMENDATION 4: That the Royal Commission recognises that there are pockets within the Jewish community, more specifically, the ultra-Orthodox community who do not respond to mainstream promotion, prevention and early intervention activities, and experience significant barriers to help-seeking and service provision within a mainstream setting.

RECOMMENDATION 5: As such, a unique response must be considered that meets the needs of the ultra-Orthodox Jewish community and has potential to be transferable to other unique communities, particularly those with ethno-cultural-religious factors not easily met within the current CALD frameworks and understandings.

RECOMMENDATION 6: That the Royal Commission recognises that the existing framework for mental health service provision does not adequately support the needs of the aged community, particularly those living in residential aged care.

RECOMMENDATION 7: As such, consideration should be given regarding how best to meet the mental health needs of older community members, including members of culturally diverse communities, whose needs fall outside of the acute setting and are not currently captured by existing service responses.

The emerging responses from the Royal Commission into Victoria's Mental Health System should include the following elements:

- Action needs to occur at the local level to effectively impact what is a major health and social issue across the diversity of communities that make up Australia;
- Local planning for mental health services must seek the input of ethno-specific/ethno-religious services;
- For the success of any initiatives, **community leadership needs to be effectively engaged in order to create buy-in, ensure cultural relevance and utilise existing community pathways to enhance resource distribution;**
- Promotion activities need to be delivered by and from within ethno-specific communities, with messaging tailored to ensure it is culturally specific and religiously relevant. Ethno-specific services who have strong connections to community are best-placed to develop and lead such initiatives;
- Mainstream services should seek the support and guidance of ethno-specific providers to deliver services through a lens of cultural humility and ensure that support services are appropriate, safe, respectful, and cognisant of the particular psychosocial needs and impacts that are conveyed by the status of belonging to a minority faith or culture;

- The mental health needs of older people who fall outside of the acute setting, particularly those living in residential aged care, are not adequately supported by the current service delivery model and should be prioritised in future planning.