MENTAL ILLNESS AND POVERTY
ENDURING THE "DOUBLE WHAMMY" OF SOCIAL INJUSTICE

"The day is short and the task is great.
It' s not for you to complete the work but nor are you free to neglect it"
(Rabbi Tarfon –Avot 2:20'21)

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Abstract

This paper has attempted to highlight the issues not raised in the JCCV Social Justice Committee (SJC) Report (2004) with particular reference to people with mental illness living with poverty. As there are no available current data about this issue for the Melbourne Jewish Community, Australian statistics for the LPDS Survey for the Australian general community have been used to provide a model for understanding the problems. These Australian figures paint a grim picture. It is known that there are Jews living in this situation of double disadvantage, but there are no data on their plight and their particular needs.

This paper urges a major survey in this area, with the aims of relieving their distress, integrating them back in the body of the Melbourne Jewish Community and altering the social structures that cause social disadvantage. A number of suggestions and solutions have been presented to encourage an active response to the problems

INTRODUCTION TO THIS DISCUSSION PAPER

In October 2004 the JCCV Social Justice Committee organised a forum entitled "Lifting the lid on poverty in the Jewish Community". This included a demographic survey which highlighted a number of important statistics based on the 2001 national census. These statistics indicated that the Melbourne Jewish Community is not the homogeneously affluent community that many believe. The relevant figures to this discussion paper on the social disadvantage of poverty and mental illness are:

1. 24,000 Jewish households, defined as a private residence (with at least one Jewish adult) comprising about 52,000 persons

2. 24% of those households have a weekly income of less than $600.00/week ($31,200.00 per year), which is classified as a <u>poor</u> income. Those households suffer <u>relative</u> poverty.

3. 5% of households have a weekly income of <$200.00/week ($10,400.00), which is a <u>very poor</u> income. Those people suffer <u>poverty.</u>

4. However, 13% of respondents did not give valid answers to the income question, nor do the above figures for households include people in other accommodation such as hostels, refuges, and homeless shelters or living on the streets.

5. Of the poor income households ($600.00/week), 53% are lone person households and 14% have dependant children.

6. In the very poor income households ($200.00/week), 75% are lone person households and 10% have dependant children.

7. About 16% of single persons in the Melbourne Jewish community live in very poor households (compared with 5% in Victorian households).

8. About 12.5% of young persons <19 years old (1338 persons) live in households on less than $600.00/week.

9. 20% of the Melbourne Jewish Community are elderly persons >65 years (compared with 12.5% in the Victorian Community).

The Social Justice Committee "acknowledges that this survey does not deal with some aspects of poverty in the Melbourne Jewish Community such as the Orthodox, single mothers, the elderly and people with disabilities and does not explore 'hidden poverty'."

This Discussion Paper is aimed to deal with some aspects not explored in the 2004 report and aims to highlight serious problems facing those suffering the double social disadvantage of poverty and

mental illness. As indicated by the statistics above, these people may represent a significant number of vulnerable individuals and families who belong to the two lower income groups and the "hidden groups".

The following discussion will consider:

A. **Definitions** of the key words Poverty and Mental illness

B. Overview of the **nature** of problem of mental illness and poverty

C. Overview of the problems **experienced** by those with mental illness in poverty

D. **Outcomes**

E. **Suggestions and solutions** including a Jewish perspective on responding to mental illness.

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A. Definitions

Poverty classically defined as “individuals, families or groups in the population can be said to be in poverty when they lack the resources to obtain the type of diet, participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged or approved in the societies to which they belong. Their resources are so seriously below those commanded by

the average individual or family that they are in effect excluded from ordinary living patterns, customs and activities".

Ref. Townsend cited in Saunders 2003.3 (1)

Poverty may be of two types

1. Absolute, which is - subsistence living, as in developing world countries – people who lack sufficient sustenance to survive
2. Relative – which involves exclusion from normal, social and economic activities. In Australia most people don't starve but often can't afford adequate food.

Mental illness

The existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and interference with personal functions (The Australian Bureau of Statistics).

Thus mental illness is more severe than a mental health problem, when someone's thoughts, feelings and relationships are troubling to them to an extent which affects their day to day lives, and an unresolved mental health might increase the risk of

a person developing mental illness. To me the emphasis in mental illness is interference with personal function.

B. Nature of the problem of mental illness and poverty

In a 1997 sample of the Australian Population, about 20% had experienced a mental illness in the previous twelve months. These include a range of anxiety, mood disorders and psychotic disorders. Anxiety and mood disorders (including depression) are more common. Less common are the psychotic illnesses. All of the conditions are problematic in their own way. The link between low income and poor health is well established and the people who suffer the greatest social disadvantage have the worst health outcomes. (2). The occurrence of schizophrenia in the lowest socio-economic group is much greater than other socio-economic groups. (3).

It has also been established that mental illness, whether as a cause or as a result of social disadvantage, significantly exacerbates these negative outcomes. The many barriers faced by this group make it vulnerable to being caught in a cycle of disadvantage, namely to get and maintain a job (4).

Other research shows that unemployment and poverty are the main causes of mental illness in Australia. In 2003, of nearly 700,000 Australians who received disability support pension (DSP), about 25%

were disabled by a psychological or psychiatric condition, making this is the second most common form of disability. (5)

C. Overview of problems experienced with mental illness and poverty

There are no current Jewish statistics on mental health.

Australian statistics

The 1997 Low Prevalence Disorder study (LPDS), which provides data on the needs of people living with psychotic disorders (hallucinations, paranoid thoughts and problems with perceptions of reality), paints a grim account of the social and economic distress of people with serious mental illness in the Australian community.

a. As stated above, the general health of the mentally ill is worse than the general Australian population. A major study in Western Australia (Lawrence 2001(6) showed that they had a mortality rate two and a half times, and higher illness rate than the rest of the population. The main causes of morbidity and mortality were heart disease, cancer and suicide.

b. In the LPDS about 50% of the people in the study have used street drugs or non-prescribed medication. In some cases there was a causal link, such as drug induced psychosis, but others use drugs and/or alcohol to self medicate for their anxiety and/or depression, In either case increasing the risk of drug addiction. It has now been found

therapeutically that better treatment outcomes are achieved by treating the underlying mental illness and the drug abuse at the same time). (7)

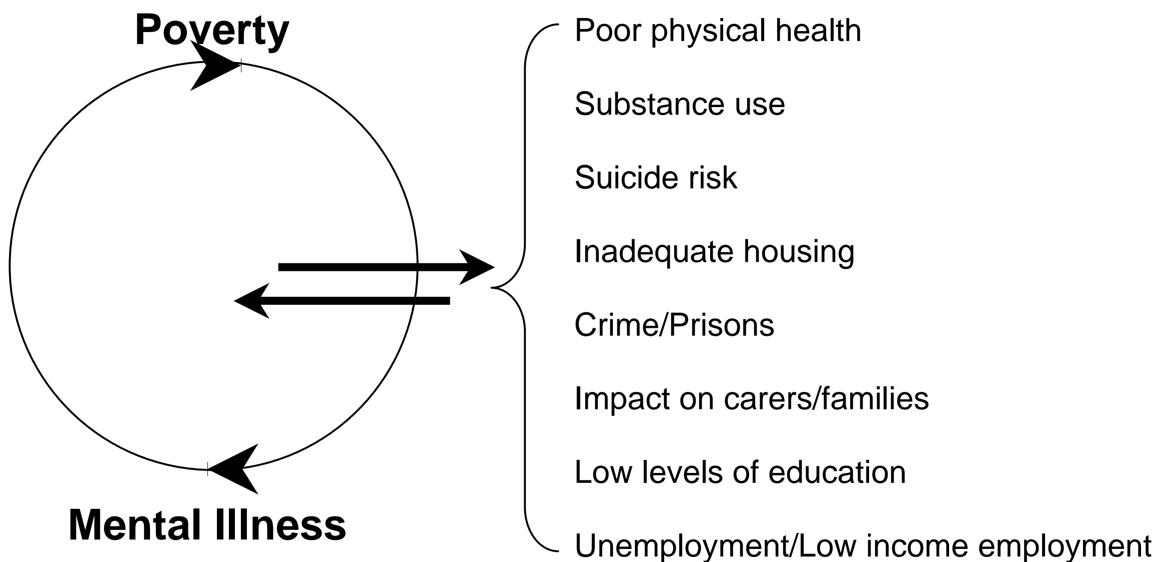
c. The risk of suicide is much higher with people with mental illness and is more likely to occur if treatment is not optimal. It is more prevalent in men, and in young men the suicide rate approximates deaths from motor accidents. The risks of suicide are increased in the first twelve months after discharge from the psychiatric ward (8) Fortunately the suicide rate has improved recently.

d. The Burdekin report (HREOC 1993) (9) demonstrated the high level of homelessness in people with mental illness. Robinson (2003) found that three quarters of the hostel population in inner Sydney had at least one mental illness. (10) Another study of the homeless population showed that it closely resembled the population of a psychiatric ward. (11). These people are at high risk of "iterative homelessness", that is "repeated and ongoing movement through accommodation in the short and long term." They move through a range of accommodation, and have difficulty in handling finances and are subject to discrimination. Robinson found that stable housing is critical to the effective case management and support that those people need. (In a survey in 2003-2004 by AIHW, there were 100,000 adults and 52,000 dependent children classified as homeless in Australia).

e. The LPDS showed that 10% of mentally ill people in the study had been arrested. In 1999 a survey of the New South Wales Corrections Health Service showed that of the male prisoners 18% had Schizophrenia and 10% Bipolar disorder. Of the female prisoners, 30% had Schizophrenia and 20% Bipolar disorder. Other research (AIHW 2001) (12) suggested that prisons were becoming the new psychiatric institutions.

f. The Impact of Mental Illness on Families and Carers. The LPDS showed that 35% of participants did not have any regular face to face contact with a close relative and 31% were living alone. Those people (only 9%) who had carers had much better outcomes.(13) However, most of the carers were family members, mothers or partners, and the survey revealed that the carers averaged 104 hours per week in undertaking their duties. Such that in 2000 the MHCA stated "It is primarily the carers who are sustaining the fabric and the operational effectiveness of the mental heath system across Australia." (14). As expected, the impact of the persons' illness on the carers and children caused a decline in their physical, mental and emotional health, and greatly increased their social isolation and reduction in their educational and employment potential. This was largely due to the time and effort to care and supervise the person, and problems of their own anxiety and feelings of loss and guilt. These effects also spread to siblings and families as a whole, and so the cycle continues.

The above study which relates to psychotic illness (hallucinations, paranoid thoughts, and problems with perception of reality) can be summarised in the following diagram which clearly shows the impact of the double disadvantage of poverty and mental illness, and how the impacts themselves become further aggravators (stressors) on the affected. What initially appears to be a cycle becomes a vortex of double social injustice.



These factors, to a varying extent, also apply to other categories of mental illness. However, another study has shown that these effects may be mitigated in higher socio-economic groups because of stronger support systems (Canadian Health Advisory Council)..

Other stressors (or aggravators) of this cycle/vortex may be predisposing, precipitating or perpetuating factors (15), which include:

Life events

(i) Family break up/divorce where women have been found to be more vulnerable.

(ii) Bereavement

(iii) Any change in circumstances (e.g. loss of employment)

Trauma

(i) Domestic violence/delinquency/child abuse

(ii) War, particularly of concern for the Melbourne Jewish Community which has a high number of survivors of the Nazi Holocaust and survivors of the Japanese occupation of Asia

(iii) Victims of terror

(iv) Military and emergency service personnel.

Both of these latter two factors may include migrants from Israel, Russia and Argentina.

Isolation and Marginalisation

(i) These may represent the 'hidden' group in poverty mentioned in the SJC report (2004).

Discrimination and Stigmatisation

(i) Which leads to further isolation.

‘Cultural’ Demands

– Trying to conform with the ‘norm’ of bar-mitzvah and wedding celebrations. (In the past one of the functions of the community chest was to help needy brides.)

Poverty

– It could be argued that poverty itself is not only a state of great economic disadvantage but also a mental health problem because of the psychological vulnerability often associated with poverty, which may include low self esteem, loss of confidence and a sense of being devalued.

The magnitude of the problems of poverty and mental illness was summed up by Professor Lord Richard Layard (December 2005, Director of the London School of Economics), “Mental illness is one of our biggest social problems, at least as important as poverty, and one of the biggest causes of misery in our society.”

C. Some commonly occurring day-to-day situations

Inertia – Being overwhelmed by illness in the form of phobic anxiety/ obsessive thoughts and behaviours/ too depressed to get out of bed so that the usual activities of daily living are neglected.

Another common scenario features a 50 year old single man living in a rooming house in an inner suburb, totally unkempt, occasionally being so short of money that he eats dog food and curdled milk three weeks old, his face covered in lacerations and bruises as a result of falls or being involved in violent altercations either due to his own psychosis or his housemates.

D. The outcomes of social disadvantage

The outcomes of the previous discussed aspects of the cycle/ vortex of poverty and mental illness are profound social disadvantage, social isolation and marginalisation from communal life, culminating in hopelessness, and often, suicide. This can only be regarded as a gross social injustice. Looking at the grim statistics from the general Australian community, it would be facile to say that "it couldn't happen to us". But it does. All of the issues discussed do occur in our community, and when they do "They are us".

E. Suggestions and solutions

Before embarking on this section of the paper, I'd like to offer my understanding of a Jewish perspective on responding to mental illness.

In the Tanach (Bible), Hosea says

> "I will betroth you forever.
> I will betroth you to Me in righteousness and justice (tzedek umishpat), in love and compassion (chessed verachamim)
> I will betroth you in faithfulness and you will know the Lord."
> (Hosea 2:19-20).

These words are said daily when binding the tefillin around the fingers.

Later in the Mishnah, Rabbi Simon the Just proclaimed that "the world is based on three things: Torah, prayer and deeds of loving kindness" (gemilut chasadim, Avot 1:2) (i.e. Deeds rather than pity.) Gemilut chasidim is one of those precepts that have no measure and is regarded as being a more all-embracing concept than tsedakah, which is limited to one-fifth of one's income. Gemilut chasidim also extends to <u>all</u> people. The Rabbis made gemilut chasidim a basic social virtue, embracing all forms of humane assistance to one's fellow man. It also includes visiting the sick (bikkur cholim), (16). The Sages tell us that "At times of illness, bikkur cholim relieves the patient's forced isolation and brings him the comfort of companionship, which in itself is a powerful aide to recovery. The visitor should speak comforting words so as not to cause worry, and bring gladness, cheer and confidence." (17) All of

which are to enhance the dignity and self respect of the patient. Is this not a therapeutic relationship? Professor Jerome Frank talks of this in his book entitled *Healing and Persuasion*, where he states: “In the course of my journey [of 50 years] I have concluded that the shared morale enhancing properties of all forms of psychotherapy contribute to the favourable outcomes. The interaction between …therapists and patients contributes more to outcomes…. than does therapeutic technique.” (18) Is this not a rewording, in modern terms, of bikkur cholim?

As stated before, people who are poor tend to have psychological vulnerability, with low self esteem, and often feel devalued (this can be viewed as a mental health problem). If one adds to this the vulnerability and sensitivity of a mental illness, you have what could be called a co-morbidity of two mental health problems (i.e. two separate conditions occurring in the one person). Any intervention which is based on the I-Thou relationship (Buber), characterised by mutuality and is a true dialogue in which both partners speak to one another as equals, can only be therapeutic. The manner of that type of intervention becomes an intervention in itself as it addresses the person’s alienation and marginalisation.

In his essay, *The Ethical Emphasis in Judaism*,(19) Rabbi Dr. Joseph Soleveichik (one of the foremost Orthodox thinkers of the 20th Century) addresses the issue of compassion (rachamim). He defines

"merachem" as doing a compassionate act, that is, something that one can choose to do or not. Whereas "rachaman" is adjectival, and describes a compassionate person, who has no other option but to do a compassionate act as it is his second nature to do so.

More recently, Rabbi Jonathan Sacks (20) defined "tsedakah" as a gift of money or a loan, whereas "chesed" is a gift of the person himself. It is significant that the Hebrew word for volunteer is "mitnadev", which literally means "one who donates himself".

Three main aims to help the needy

1. The major aim of our response to social injustice must be to alleviate individual distress.
2. Promote recognition and understanding of the impact and needs of people with mental illness living in poverty.
3. Alter the social structures that cause social disadvantage.

Specific suggestions (in addition to those already proposed by SJC) include

1. Need for a survey. I understand that in the near future an Australia wide Jewish demographic survey is planned. My suggestion is that the issues of mental illness and poverty are included, with special emphasis on identifying the nature of the hidden group of marginal and isolated individuals.

Armed with data from the forthcoming survey, similar discussion papers on the disabled, single mothers, the Orthodox community and the elderly could be undertaken.

2. The community chest (tsadakah fund or kupah) is needed to fund loans/ subsidies/ poverty relief/ training/ publicity, and also to avoid duplication of services by various agencies.[1]

3. An army of trained compassionate volunteers. To encourage volunteers and train them to be carers/ drivers/ hospital and prison visitors/ community workers/ home help/ handymen/ creative people to help with activities/ people to help clients with problems of bureaucracy etc. The Jewish perspective of chesed to be included in the training.
4. Education within the Melbourne Jewish community. A) The clients to be taught (in their own language) of the benefits and resources available to them. B) Educate the carers about the needs of clients and to recognise the early signs of deterioration of the client's mental health, that is, to act as "spotters", particularly in the young having their first psychotic episode, when there is an urgent need for specialist treatment. C) Educate the general Jewish community to understand, respect and support the needs of the disadvantaged, and to accept and include them in the community without discrimination and

[1] Maimonides said that he had never encountered a town that had no tsadakah fund.

stigmatisation. Perhaps, in cooperation with other faith and ethnic agencies such as Anglicare, Salvation Army, Brotherhood of St Lawrence, St Vincent de Paul Society, etc, information of this nature could be provided to the wider Australian community.

5. Vocational support. To encourage clients to return to work/ study, if possible. In several studies, an important goal of clients was to return to work or study. It has been identified (22) that treating health personnel have been reluctant to allow clients to return to work or study. In the U.K., Professor Layard discusses the "Pathways to Work" program. This program is part of a government initiative in which a change in attitudes regarding returning to work has allowed fifty percent to cease disability benefits within six months of the program. A supportive employment environment would facilitate this process, perhaps for example, amongst local Jewish businesses. In addition, after hours skills and vocational training for the low income earners could be provided to assist them improve their employment and earning prospects.

6. Liaison with mental health professionals. This is often an urgent matter, particularly after hospital discharge, and may involve GPs, psychiatrists, psychologists, mental health teams, social workers and district nurses. As previously stated, this is a time when clients are vulnerable, especially if the discharge was premature or a discharge summary was not finalised or sent. Liason is often necessary between hospital staff and caring

agencies before discharge to allow distribution of discharge kits for clients. Another study by Bridge (21) urged the need for a "good Samaritan" to be with a person who has experienced a failed suicide attempt, or who has suicidal thoughts.

7. Expand activities for clients. Increased and varied activities for the socially disadvantaged, for example, home visitors/ group activities/ creative activities/ celebration of Jewish festivals/ telephone linkup/ support groups all need funding and volunteers.
8. Respite facilities for clients and/ or their families, particularly the carers.
9. Supported accommodation. Because of iterative homelessness and its problems, more volunteers and workers are needed to support people in the most stable accommodation possible.
10. Expanded counselling services for victims of family breakup/ violence/ abuse/ bereavement and other traumas.
11. More supervised attention to medical/ dental services to prevent further deterioration in physical/ mental/ dental health, to encourage clients to have regular check-ups, and if necessary, to drive them to appointments.
12. Subsidise the 'gap' for the new Medicare rebates for clinical psychologists. The Federal government has announced the availability of Medicare benefits to clinical psychologists. The details are still not clarified, but should make services more

affordable. Perhaps the community chest could subsidise the gap payment.

13. Cooperation with other faith agencies. We could cooperate with other agencies, who have a long experience with social engagement, in lobbying governments regarding matters of social policy.

Conclusion

This paper has attempted to highlight the issues not raised in the SJC Report (2004) with particular reference to people with mental illness living with poverty. As there are no available current data about this issue for the Melbourne Jewish Community, Australian statistics for the LPDS Survey for the Australian general community have been used to provide a model for understanding the problems.

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