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Bioethics Update

"A Profound Transformation of Culture"

Mental Health, Ethics and the Social Teachings of the Church

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"Mental health is integrated with one's physical, social, spiritual and economic well-being. Hope for the future is truly realized if there are genuine expectations that inequities within society will be addressed. My friends {…} have eloquently spoken about what it feels like to have a place to call your own, and a social network of friends. I hope you heed our collective call that individual recovery is impossible when struggling with the consequences of poverty alongside stigma and discrimination" [1]

So states Raymond Cheng in his personal submission to the 2006 Senate of Canada Report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services.* In his submission, Cheng makes an eloquent appeal on behalf of others, who, like him, live with mental health problems and illness, and on behalf of their families and caregivers. His call is for greater attention to the social context of mental health, mental illness and recovery.

For what is most clear from the Senate Report is that for those who live with mental illness, and for those who support them, the social determinants of mental health are at the forefront in terms of ongoing care and recovery. Moreover, their articulation of the issues and their key insights are beginning to be reflected in mental health research and in materials prepared for public education in the field.

Based on the research findings of Health Canada, the Canadian Alliance on Mental Illness and Mental Health, for example, has listed the following determinants as critical for mental wellbeing:

- Income and social status
- Social support networks
- Education
- Employment and working conditions
- Social environments
- Physical environment
- Personal health practices and coping skills
- Healthy child development
- Health services

The Alliance concludes, "When these determinants of health are strong and in place, mental health is positively impacted. But when they are weak or missing, mental health problems can result…It is essential for supports to be in place so that all Canadians, whether young or old, whether living with mental illness or not, can maximize their mental health." The Alliance thus calls for a positioning of mental illness and mental health prominently within both the health and social policy fields. [2]

To achieve the integrated health and social positioning called for by the Alliance will, however, require some significant shifts in the emphases in mental health care. To begin, mental health concerns in general must be afforded much greater attention. Mental illness constitutes the single largest category of disease affecting Canadians. Somewhere in the range of 20 percent of the population will experience mental illness at some time during their lives. [3]

Globally, mental illness is associated with substantial morbidity and mortality. Mental illnesses are among the leading causes of prolonged disability worldwide. [4] Numerous national and international reports have brought these serious facts to light and yet despite the calls to action contained in the reports there is still insufficient attention paid to the problems facing so many people. Disproportionate allocation of resources and services are directed to the cure and alleviation of so-called physical illnesses at the expense of mental health care.

Clearly, important progress has been made medically toward the treatment of people with some sorts of mental illnesses; notably in the field of psychopharmacotherapy. But even for those who may benefit in part from this medically-focused approach it is of little value if the social conditions are not in place to make access to and continuation of therapy possible. The narrowly construed medicalization of mental health care may at best mask the context within which those with mental health difficulties live. At worst, it may anaesthetize our social conscience, and dilute responsibility, with respect to mental health and the social conditions necessary to engender and maintain it. It fails to give due recognition to the reality of the interrelationships between social environment and mental wellbeing.

Those who live with mental illness and those who support them call for more integrated approaches to mental health and mental illness. In their personal submissions to the Senate Report they speak of the need for a recovery-oriented system and recovery, many state, is about hope that does not necessarily equate with cure. "Very broadly" what is needed is that "the goal of mental health policy should enable people to live the most satisfying, hopeful and productive life consistent with the limitations caused by their illness." [5]

The biomedical model of healthcare while important is not sufficient. Adequate housing and income, employment assistance, education, training, social connections, peer support, family, friends and community services are critical, respondents say. Within the Senate Report many people speak poignantly of the absence or presence of such fundamental conditions for mental wellbeing and recovery. They speak of difficulty in finding employment. "In my own case" says one respondent named Karen, "because I had been so open about my illness, it took me a number of years to find decent, secure employment. I felt that people now saw me as a gamble. If I had survived cancer, diabetes or high cholesterol, I'm not sure I would have faced the same challenges." [6] Here "Karen" makes clear not only her practical difficulty in finding work but also the added burden of pervasive stigma and discrimination that so many people who experience mental illness face socially and professionally.

As Graham Thornicroft in his recent book on the topic, *Shunned: Discrimination against People with Mental Illness*, points out, "people with mental illness are subjected to systematic disadvantages in most areas of their lives." [7] Judi Chamberlin, who has personally experienced such stigmatization and prejudice says in her foreword to Thornicroft's book, "Once a person is labeled 'mentally ill', he or she loses fundamental rights that everyone else takes for granted…Those of us who have been labeled, have always known that what others have defined as the 'stigma problem' lies at the root of the difficulties we face as we attempt to improve the conditions of our lives and to insure that we obtain the same legal and social status as people without psychiatric labels." [8]

For people living with mental illness, and particularly for those who rely on medication, the employment problems they face add layers of further difficulties. Work available is often at a minimum wage level despite an individual's gifts, skills or qualifications and the obtaining of such work commonly requires loss of other income assistance such that a person becomes unable to afford the cost of necessary medication. Many are caught in a very problematic cycle as they seek the sustaining and fulfilling conditions so necessary for recovery and optimal mental wellbeing - conditions that all people need and desire. Without enriching life opportunities that satisfactory work and social connections afford, issues of self-esteem commonly become a hard challenge in daily life. Without sufficient income safe and adequate housing is unobtainable. Lonely, often ill-maintained boarding houses become the only option available. "Some struggle with poverty so grinding and housing so appalling it would challenge the sanity of even the strongest among us", says Scott Simmie in his personal submission to the Senate Report.[9]

Conversely, those who are able to break through the social hurdles speak of the healing influences that become possible when social conditions are positive. Linda Chamberlain for example says, "When I first saw my one-bedroom apartment, I could not believe it was mine. I did not think that I deserved such a beautiful place. I actually thought it might have been a mistake and it would be taken away from me. I had windows, they opened and I could see out; oh, the light, the sun. I could smell the grass and hear the birds. I had my own bedroom, my own washroom. I have a full kitchen with a stove and refrigerator. Now I am able to cook my own meals and I can entertain with pride … My life has completely changed since I moved into my own apartment. It is not just an apartment. It is my home. I am now a productive member of society." [10] In Linda Chamberlain's words the hope and wellbeing that an integrated recovery model of mental health makes possible, becomes real.

Yet such a model, so needed, still seems very far from reality. Is it possible that the contribution of bioethics might help transform our vision for and practice of mental health care?

The answer to such a question seems to me to be both "Yes and No". In one respect the emphasis that modern bioethics has placed on the individual and his or her dignity and rights has gone some way to remind us of the dignity of all persons with our own ever changing strengths and limitations. Bioethics has helped us address and correct abuses of the past and particularly abuses in clinical care and research that have affected people who live with mental illness. The attention that bioethics has given to individual rights has challenged prejudice and social exclusions. Nevertheless, our recent models of bioethics have tended to focus almost exclusively on the medical and mostly physical domain even in the field of psychiatry.

Some bioethical reflection has been concerned with disease labeling and the stigma and prejudice that arise from the ways in which disease is defined. What has been largely missing from models of bioethics, however, is adequate acknowledgement of the social context of health and illness; the very context toward which those living with mental illness and those who walk with them are calling us.

What is hopeful is that the face of bioethics which both supports and challenges our systems of healthcare is seemingly beginning to change. It is slowly widening its scope to include environmental, public and global health concerns. This holds promise for a better integration of health and social policy so critical for mental wellbeing and recovery. Christian understandings of healthcare and bioethics and Catholic contributions, especially those concerning mental health, have the potential to contribute to the realization of that promise.

The Christian tradition of caring for the sick serves as a reminder that healing has a much broader scope than medicine. Historian Gary Ferngren points out that through the ages the Church's concern for the sick has been fundamentally "directed toward relieving individual suffering rather than rendering therapeutic treatment". [11] As such, the tradition embodies the understanding that health and illness do not only result from individual factors but are related to social conditions.

Contemporary Catholic thought on the nature of healthcare reflects an integration of the Church's gift of social teaching with concerns for health and wellbeing. Such thought emphasizes the uniqueness and worth of every human being. It gives recognition to the unity of the human person as a biological, psychological, social and spiritual being and it embraces the social nature and context of health. For Catholics then, healthcare goes well beyond the medical project. It includes promoting social conditions that enable people to thrive. A Catholic understanding of health care also recognizes the importance of relationships with self and others. For physical or mental illness can arise when there is loss or estrangement from loved ones, loss of self esteem, isolation and loneliness. [12]

The Catholic Social Tradition has also, since the middle of the twentieth century, begun to inform the Catholic bioethics that serves healthcare. Theologian Lisa Sowle Cahill says that as such, Catholic bioethics "expands our vision of life and health outside the delimited context of healthcare and medical interventions." [13] It engages the social context of health and wellbeing and it espouses the principle of the preferential option for the poor and most vulnerable in our societies.

In recent developments within the Church concerning mental health there is clear evidence of the integration of social teaching, healthcare and ethics. In a homily by Cardinal Javier Lozano Barrigan marking the 2006 World Day of the Sick, for example, he says, that we must place people who are mentally ill at the centre of our attention. We must pay special attention to the social conditions that impact people's lives. The Cardinal highlights the importance of subsistence, work, formation, education, inclusion within communities, help networks, freedom from violence and family cohesion and support. [14]

Similarly, Pope John Paul II, in an address to the participants attending an international conference sponsored by the Pontifical Council for Pastoral Assistance to Health Care Workers reminded us of our obligations to invest in "adequate human, scientific and socio-economic resources" vital for mental health care.

Pope John Paul was clear that "whoever suffers from mental illness 'always' bears God's image and likeness, as does every human being". This "must spur both the personal and collective conscience to a sincere reflection on our behaviour toward those persons who are suffering from mental illness."

Responding directly to issues of stigma and discrimination, he asks, "Is it not true that all too often these persons encounter indifference and neglect, when not also exploited and abused?" As Christians John Paul

said, we cannot close our eyes to forms of behaviour which seem to ignore human dignity and which trample on inalienable rights. As disciples we are called to see the image of the "suffering" Christ in all people who are sick, opening our hearts to them, spending ourselves to walk with, support and care for them. "It is everyone's duty to *make an active response*": our actions must show that mental illness does not create insurmountable distances, nor prevent true and authentic relationships in society.

Indeed, John Paul concluded, Christian love "should inspire a particularly attentive attitude toward those who live with mental illness. [15] Such an attentive attitude will call us first to a "profound transformation of culture" to meet the primary expressed needs of those who live with mental illness. [16]

It will demand our practical engagement with and for them and their caregivers not only in hospitals and healthcare institutions but in our communities, on our city streets, in schools, colleges, housing projects and importantly in our parishes. For only then will our society be one that is truly conducive to wholeness, and social and personal health.

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Endnotes

1 The Senate of Canada. The Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*. May 2006, p. 6 (Raymond Cheng. Personal Submission to the Senate Committee).

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3 Ibid.

4 Ibid.

5 The Senate of Canada Committee Report, p. 45

6..Ibid, p. 7 (Karen—personal submission)

7 Graham Thornicliffe, *Shunned: Discrimination against People with Mental Illness* (Oxford: Oxford University Press, 2006) p. 170

8 Ibid. pp. X1, X11

9 The Senate of Canada Committee Report, p.8
Scott Simmie, Personal Submission to the Senate Committee)

10 The Senate of Canada Committee Report, p.11 (Linda Chamberlain, Personal Submission to the Senate Committee)

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13 Lisa Sowle Cahill. *Bioethics and the Common Good: The Père Marquette Lecture in Theology 2004* (Milwaukee: The Marquette University Press, 2004) p. 8

14 Cardinal Javier Lozano Barrágan, "Homily for the Solemn Eucharistic Concelebration in the Cathedral of Adelaide, Australia: X1V World Day of the Sick, February 11, 2006

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16 See: Benedict Ashley, Jean DeBlois, Kevin O'Rourke. *Health Care Ethics: A Catholic Theological Analysis* 5th. Edition (Washington D.C. Georgetown University Press, 2006) p. 129