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OPINION OF THE WORKING GROUP ON ETHICS IN RESEARCH AND MEDICINE

MENTAL HEALTH IN EUROPE

Ethical and Religious Considerations

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Original version

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OPINION ON
MENTAL HEALTH IN EUROPE
ETHICAL AND RELIGIOUS CONSIDERATIONS

1. THE EUROPEAN UNION AND MENTAL HEALTH

1.1. Development of EU policy on mental health

The primary responsibility for health policy and for organising and delivering medical care rests with individual member states of the European Union, not the EU as such. Nevertheless, European social and economic policies can have a significant impact on human health, either positively or negatively. The Treaty on the Functioning of the European Union therefore stipulates that a 'high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.'[1] This duty is the basis for an appropriate EU-level interest in public health in relation both to 'physical and *mental health*.'[2]

Definition of key concepts in mental health promotion was a prominent element in the first European Community Public Health Program (1994-2000). In 1999, towards the end of this Program, there was a joint World Health Organization - European Community meeting entitled 'Balancing Mental Health Promotion and Mental Health Care'[3] and between 1999 and 2005 there were a number of European Community sponsored conferences and policy initiatives related to mental health.[4] Of particular significance was a joint World Health Organization - Europe Ministerial Conference on mental health in January 2005.[5] That conference led to a European Commission Green paper[6] and to the launch in 2008 of the *European*

1 *Treaty on the Functioning of the European Union* Title XIV: Public Health, Art. 168, Official Journal of the European Union EN, 26.10.2012, C 326/123, http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:12012E/TXT&from=EN.

2 *Idem*, emphasis added.

3 *Balancing Mental Health Promotion and Mental Health Care: A Joint World Health Organization (WHO)/European Commission (EC) Meeting*, Brussels, 22-24 April 1999, http://www.who.int/mental_health/media/en/43.pdf.

4 *Action for Mental Health Activities co-funded from European Community Public Health Programmes 1997-2004* Report prepared for the European Commission, Health and Consumer Protection Directorate-General, by Professor Ville Lehtinen, December 2004, pp. 23-27, http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/action_1997_2004_en.pdf.

5 *Mental Health: Facing the challenges, building solutions: Report from the WHO European Ministerial Conference*, January 2005, http://www.euro.who.int/__data/assets/pdf_file/0008/96452/E87301.pdf.

6 *Green Paper: Improving the mental health of the population. Towards a strategy on mental health for the European Union*, November 2005, http://ec.europa.eu/health/archive/ph_determinants/life_style/mental/green_paper/mental_gp_en.pdf.

Pact for Mental Health and Well-Being.[7]

The European Pact called for action in five priority areas:

I. Prevention of depression and suicide

II. Mental health in youth and education

III. Mental health in workplace settings

IV. Mental health of older people

V. Combating stigma and social exclusion

A European initiative in 2013, *Joint Action Mental Health and Well-being*,[8] has built on the European Pact, applying its priorities to five areas:

• promoting action against depression and suicide and implementation of e-health approaches;

• promotion of mental health in schools;

• promotion of mental health at the workplaces;

• developing community-based and socially inclusive mental health care for people with severe mental disorders; and

• promoting the integration of mental health in all policies.[9]

Three of these five areas relate clearly to three of the five priorities in the European Pact and one, 'community-based and socially inclusive mental health care' covers two priorities: 'mental health in older people' and 'combating stigma and social exclusion'. The new element added in the joint action is the integration of mental health considerations into 'all policies.' It may be noticed that this last element reflects the place of mental health in the EU Treaty[10] and indeed the fundamental rationale for having European policy on mental health. It is precisely because of

7 *European Pact for Mental Health and Well-Being*. EU High-Level Conference Together for Mental Health and Wellbeing, Brussels, 12-13 June 2008, http://ec.europa.eu/health/mental_health/docs/mhpact_en.pdf.

8 http://www.mentalhealthandwellbeing.eu/.

9 These are set out here in such a way to bring out the relation between the five areas and the five priorities.

10 *Treaty on the Functioning of the European Union* Title XIV: Public Health, Art. 168.

the possibility that all or any EU policies may impact upon physical or mental health and wellbeing that public health falls within the responsibility of the EU.[11]

1.2. The state of mental health needs across Europe

Physical and mental health needs vary between individuals, vary between groups within society (for example, by social class, age, gender, physical or learning disabilities[12]) and vary between countries. Nevertheless, it is possible to make some general comments about mental health needs across Europe. According to the World Health Organisation in 2005, 'neuropsychiatric disorders are the second greatest cause of the burden of disease on the [European] Region… [they] account for 19.5% of all disability-adjusted life-years (DALYs).'[13] More than a decade later, it remains the case that mental health problems 'impose a major burden on individuals, society and the economy' across Europe and 'represent 22% of the EU's burden of disability, as measured in Years Lived with Disability (YLD).'[14]

Among the most devastating effects of mental disorder is suicide. In 2005 it was reported that 'nine of the ten countries in the world with the highest rates of suicide are in the European Region.'[15] In the European Union in 2008 it was estimated that there were 58,000 suicides per year and that 'eight Member States [were] amongst the fifteen countries with the highest male suicide rates in the world.'[16] However, it should also be noted that there has been a decline in the overall rate of suicide in Europe over the past twenty years,[17] in contrast to the United States where the

11 With due regard to the health policies of individual Member States.

12 See, for example, Holland, A. J., & Jacobson, J. (Eds.). (2001). *Mental health and intellectual disabilities: Addressing the mental health needs of people with intellectual disabilities*. Final report by the Mental Health Special Interest Research Group of the International Association for the Scientific Study of Intellectual Disabilities (IASSID) to the World Health Organisation: IASSID.

13 *Mental Health: Facing the challenges, building solutions*, January 2005, p. 1.

14 *European Framework for Action on Mental Health and Wellbeing*, Final Conference - Brussels, 21-22 January 2016, p. 4 http://www.mentalhealthandwellbeing.eu/publications. Note that this measure is not directly comparable to the DALY, and the DALY figure for 2005 and YLD figure for 2016 apply to different sets of countries (the former to the 'European Region', which includes countries such as the Russian Federation, the latter to the European Union).

15 *Mental Health: Facing the challenges, building solutions*, January 2005, p. 2.

16 *European Pact for Mental Health and Well-Being*, June 2008, p. 2.

17 OECD (2012), *Health at a Glance: Europe 2012*, OECD Publishing, pp.28-29, http://dx.doi.org/10.1787/9789264183896-en.

rate has been rising.[18] This trend across Europe is, at least in part, the result of efforts that many countries have been making to implement evidence-based prevention tools and therapies.Thus in 2016 it was reported that the 'majority of the participating Member States [in the European Union] have national policy programs for tackling depression and suicide.'[19]

While there has been progress, it remains the case that the picture is highly variable. In 2008, reported rates of suicide in Member States differed 'by a factor 12'.[20] There are some general patterns, for example Member States on the Mediterranean (Spain, Italy, Greece) tend to have lower rates of suicide. So also, countries that were formerly part of the communist bloc have a legacy of very high rates of suicide. However, some of the countries that had the highest rates have made the most progress.[21]

In general, in relation to the challenge of promoting mental health across Europe it is clear that 'progress has been very uneven across countries'.[22] It is also clear that there remains a significant implementation gap between the need for mental health services and access to such services, significantly larger than the implementation gap for most physical disorders. In a survey across the European Union published in 2003, '90% of people who said they had mental health problems reported they had received no care or treatment in the previous 12 months. Only 2.5% of them had seen a psychiatrist or psychologist.'[23] In 2016, despite increased evidence for cost-effective interventions to treat and prevent mental disorders, 'only about half of people with a severe mental disorder, and far less with a mild-to moderate mental disorder, receive adequate treatment.'[24]

The great extent of unmet need for mental health services is, in part, due to failure to identify the need. One example cited at the 2016 conference was under-

18 Curtin SC, Warner M, Hedegaard H. 'Increase in suicide in the United States, 1999–2014.' NCHS data brief, no 241. Hyattsville, MD: National Center for Health Statistics, 2016, http://www.cdc.gov/nchs/products/databriefs/db241.htm.

19 *European Framework for Action on Mental Health and Wellbeing,* January 2016, p. 9.

20 *European Pact for Mental Health and Well-Being,* June 2008, p. 3.

21 *OECD Health at a Glance: Europe 2012,* pp.28-29.

22 *European Framework for Action on Mental Health and Wellbeing,* January 2016, p. 11.

23 *Mental Health: Facing the challenges, building solutions,* January 2005, p. 3. See also, as regards the United Kingdom, *How mental illness loses out in the NHS*, The London School of Economics and Political Science, Centre for Economic Performance, June 2012, esp. pp. 2 and 15-17.

24 *European Framework for Action on Mental Health and Wellbeing*, January 2016, p. 5.

recognition of depression which 'is estimated to affect 50% of the cases.'[25] Similarly, despite mental health in youth and education being named as a priority area in 2008, in 2016 it was still the case that 'only a minority of children or adolescents receive any treatment' for mental health problems and implementation of effective school based interventions to promote mental health was still 'largely absent'.[26]

25 *Idem*, p. 9.

26 *Ibidem*, p. 17.

2. THE CHURCH AND MENTAL HEALTH

2.1. The relationship of mental health and religion

There is good evidence that religiosity,[27] in the form of regular Church attendance, is associated with lower levels of depression and is a resource that can help people cope with negative life events including episodes of ill health.[28] Research has also demonstrated an inverse relationship between individual religious belief and rates of suicide: it is speculated that 'exposure to a religious environment may protect against suicide by reducing its acceptability'.[29] Furthermore, 'the protective effect of a religious affiliation, and particularly of the Catholic faith, is evident both for assisted and non-assisted suicides'.[30]

In general and for the most part Christian belief and practice and the support of a Christian community bring mental-health benefits. Nevertheless, it is necessary to add some important qualifications to this statement. First of all, one should not think religion as a 'mental health intervention' comparable with psychological and psycho-pharmacological interventions; on the contrary, it addresses a different aspect of the person[31].

Secondly, one should be clear that all good things, apart from God, can become the means or the occasion of evil. Indeed, the greater the good, the worse the effect if it goes bad: *corruptio optimi pessima est*.[32] Hence personal harm that occurs within the family and within the Church can leave the deepest scars. Such injury may be due to abusive individuals but may also reflect a problematic culture associated with a particular faith. Pope Francis has observed that 'in the popular

27 'Religiosity' should not be confused with 'spirituality'; for example, 'new age spirituality'. See for this distinction, Pontifical Council for Culture and Pontifical Council for Interreligious Dialogue, '*Jesus Christ the bearer of the water of life, A Christian reflection on the 'New Age*", 2003.

28 H. Koenig (2008), *Medicine, Religion, and Health: Where Science and Spirituality Meet West Conshohocken*, PA: Templeton Foundation Press.

29 Neeleman, J., Halpern, D., Leon, D. and Lewis, G. (1997), 'Tolerance of suicide, religion and suicide rates: an ecological and individual study in 19 Western countries' *Psychological Medicine* 27:1165-1171.

30 Steck N, Junker C, Maessen M, Reisch T, Zwahlen M, Egger M; Swiss National Cohort 'Suicide assisted by right-to-die associations: a population based cohort study'. *Int J Epidemiol.* 2014 Apr;43(2):614-22, citing Spoerri A, Zwahlen M, Bopp M, Gutzwiller F, Egger M. 'Religion and assisted and non-assisted suicide in Switzerland: National Cohort Study'. *Int J Epidemiol* 2010;39:1486–94.

31 See 2, 2.2., b. *in fine*, below.

32 'The corruption of the best is the worst': A common Latin adage quoted, for example, by Pope Francis *Misericordiae Vultus*, §19, though wrongly ascribed to Gregory Great.

cultures of Catholic peoples, we can see deficiencies which need to be healed by the Gospel: machismo, alcoholism, domestic violence, low Mass attendance, fatalistic or superstitious notions which lead to sorcery, and the like.'[33] Furthermore, Pope Francis has argued that, to prevent the Church from 'harming many souls'[34] its institutional culture also needs to be reformed.[35]

Moreover, authentic Christian belief and practice, and the community constituted by such belief and practice, promotes human flourishing and this is seen in the positive effect that Christianity can have on mental health.[36] However, illness, whether physical or mental, is also a time of spiritual need and can present a challenge to faith, as well as an opportunity for spiritual growth. Mental illness in particular may 'deprive someone of the ability to direct their own lives'[37] and the Christian suffering with mental illness may struggle with negative emotions, such as guilt and despair, relating to their religious beliefs. At such times it can seem that God is distant and faith may therefore be experienced as a source of further suffering[38].

33 Pope Francis *Evangelii Gaudium*, §69.

34 The terms 'mind', 'spirit' and 'soul' are profusely used in this Opinion, although their definitions are extremely complex and are subject to great controversy. It is not the intention of this document to provide a precise definition of these terms. In general, the term 'soul' is used herein in the Aristotelian-Thomist sense of the principle of life (whether biological, emotional, psychological, or intellectual), such that whales and even cabbages have souls. It is true however that this has fallen out of use as a common understanding of 'soul' and it is typically used for the spiritual/religious aspect of the person (closer to the word spirit). It is unclear where mental illness fits in a Thomistic anthropology - but somewhere at the interface of the emotional (sensitive) and cognitive (intellect) life. This affective-cognitive aspect of the person, distinct from the intellectual or moral, is sometimes also expressed by the term 'psyche'. Finally, people speak of mental health and the mind as including affective (and behavioral) as well and intellectual aspects, but we also speak of 'mental arithmetic' and 'broadening the mind' (by travel or education) where these are cognitive.

35 Pope Francis 'Presentation of the Christmas Greetings to the Roman Curia', 21 December 2015, https://w2.vatican.va/content/francesco/en/speeches/2015/december/documents/papa-francesco_20151221_curia-romana.html.

36 On the contribution of spirituality to mental health see also Cook, C., Powell, A., Sims, A. (eds.) 2009. *Spirituality and Psychiatry*. London: RCPsych Publications; Koenig, H., King, D., Benner Carson, V. 2012. *The Handbook of Religion and Health*. Oxford: Oxford University Press; Koenig, H. 2009. 'Research on Religion, Spirituality and Mental Health: A Review'. *Canadian Journal of Psychiatry* 54: 283-291.

37 Day for Life Message 2008 (agreed text used in England and Wales, Scotland, and Ireland), http://dayforlife.org/Home/DFL-Themes/Mental-Health/2008-Message; http://www.catholicbishops.ie/2008/10/01/day-for-life-2008-the-lord-is-close-to-the-brokenhearted; cf. also Spanish Episcopal Conference, *Religious assistance in hospital. Pastoral guidelines*, 1987, §105, http://www.conferenciaepiscopal.es/wp-content/uploads/2016/03/ARH.-Orientaciones.pdf (in Spanish).

38 Related to a mistaken but prevalent idea that religion as a delusion can be bad for mental health, see also 2, 2.2., b. *in fine*, below.

Furthermore, an important role of the Church in this respect is 'to pray for those with mental health difficulties: that they are not placed on the margins, but treated with respect and lovingly supported as they live their life with dignity.'[39] Mental disorder can isolate the person and this isolation impedes recovery. Psychiatric services can address one aspect of the problem but people also need human support and companionship from friends, family and/or community. In modern society, and especially in cities, traditional forms of communal life are harder to find and faith communities are important examples. In Ireland and in Britain the Catholic bishops have urged parishes to be open in offering friendship to people with mental health problems, stating that 'the parish community has a very important role to play in accompanying people as they journey towards recovery.'[40]

Finally, religion (and in particular the Christian religion) is relevant to mental health inasmuch as it informs the ethics of mental health care insofar as in its teaching and practice it helps promote an environment which is supportive of mental health and well-being. This is analogous to the relevance of good working practices, communication within families and just policies on migration for mental health - these are not primary concerned with healthcare but they have an impact on mental health. Indeed Catholic Christianity also affects mental health indirectly by engaging positively with these other social and justice issues.

2.2. Christian ethics and mental health

The traditions of Christian ethical thought and Catholic social teaching have many resources to bring to reflection on mental health and wellbeing. In the remainder of this section the ethical understanding of mental health will be explored in relation to four key themes: the human person; treatment and care of the whole person; allocation of resources to mental health; and autonomy and treatment decisions. In the last section these themes will be applied to the five priorities of the European Pact, giving particular attention to the first priority: prevention of depression and suicide.

a. The human person

The starting point for Catholic ethical reflection on mental health is the dignity of the human person. This dignity is not based on human achievements but on the creation of human beings in the image of God. When Pope John Paul II was

39 Benedict XVI's Prayer Intention for 2008, quoted in Day for Life Message 2008.

40 Day for Life Message 2008.

asked whether someone suffering from mental illness was 'always' in the image and likeness of God, his answer was unequivocal:

> The response to the theme's question is clear: whoever suffers from mental illness 'always' bears God's image and likeness in himself, as does every human being. In addition, he 'always' has the inalienable right not only to be considered as an image of God and therefore as a person, but also to be treated as such.[41]

It might be thought that image of God in the human being is found only in the 'mind' or the 'soul', but Thomas Aquinas, who holds a special place among Catholic philosophers and theologians,[42] is clear that the image of God is found in the whole living person, body and soul. A soul separated from the body would be less in the image of God.[43]

It would also be a mistake to acknowledge the dignity of the human person, body and soul, but to see the person in isolation. In Christian theology the word 'person' was first used to describe the Holy Trinity of persons: Father, Son and Holy Spirit; and then unity of Jesus Christ as one person fully Divine and fully human. This context helps deepen the Christian understanding of what it is for a human being to be a person. One implication of this is highlighted by the Second Vatican Council, there is 'a certain parallel between the union existing among the divine persons and the union of the sons of God in truth and love'.[44] Each person is a unity and has his or her own dignity but persons always exist in relation to other persons, as a communion.

b. Treatment and care of the whole person

From the unity of the human person, soul and body, it follows that mental and physical health should be understood in relation to one another, but not as reducible to one another. Some mental disorder is clearly related to brain chemistry and pharmacological treatment is very effective for some patients. Nevertheless, even where imbalances in the brain play a major role, the effect on the person will still

41 Pope John Paul II 'Mentally Ill are also Made in God's Image', Address at a conference sponsored by the Pontifical Council for Pastoral Assistance to Health-Care Workers, 30 November 1996, http://www.ewtn.com/library/PAPALDOC/JP96N30.htm.

42 For example, Thomas Aquinas is cited as the example to follow par excellence in Vatican II, Declaration on Christian Education (*Gravissimum educationis*) 10; and is explicitly invoked by Pope John Paul II in *Veritatis splendor* §78; and *Evangelium vitae*, §72.

43 *De Potentia* Q. 5, Art. 10 ad 5.

44 *Gaudium et Spes*, §24.

depend to a large extent on the human environment and the person's psychological history[45].

In some cases, perhaps most obviously in Post-Traumatic Stress Disorder, it will be external and psychological factors that lie at the root of the problem. It is not only the brain that affects the mind but the mind that affects the brain. It can also be that a person's general state of physical health, pattern of life, diet and exercise, or the presence of physical illness or disability, can alter a person's mental resilience. Body and soul affect one another.

These considerations show that mental health cannot be reduced to a brain function and disorders treated only by pharmacological means. In parallel to such approaches there also needs to be consideration of the person's story and way of thinking. There are a variety of 'talking therapies' some of which have been shown to be effective in some patients. However, typically it is much more difficult to access these therapies as they are often rationed, subject to delay, or not publicly funded. 'Talking therapies' here should not be understood reductively, exclusively as psycho-therapy, but, more generally, interventions other than pharmacological, covering also behavioral, social and art/activity therapies. Behavioral therapies, in particular, can be efficient in helping people overcome stereotypes or help enter the language in some cases of the autism spectrum disorders. The challenge in all these therapies at the service of the mental health is to treat the persons as unique and not reduce them to mechanical operations, either of the brain or of the unconscious.

The unity of the person, soul and body, and the theological, anthropological and sociological understanding of the person always in relation to other persons, points to the need for mental health to be understood in the context of social factors. This is also an implication of the teaching of Pope John Paul II that society needs to develop 'an authentic human ecology'[46]. Pope Francis has spoken in still broader terms of the need for an 'integral ecology'[47], which includes environmental, economic and social aspects. From a theological perspective there is a great virtue in seeing mental health first through the lens of public health. Persons exist in relationship and it is possible to cultivate a human ecology that promotes mental health.

It is an important tenet of Catholic theology that being and goodness are prior to

45 Cf. WHO, *Risks to Mental Health: An overview of vulnerabilities and risk factors*, August, 2012, http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf.

46 *Centesimus annus*, §38. See also §39.

47 *Laudato si*, esp. §§137-162.

privation and evil. Health is an aspect of human flourishing and can be understood without reference to illness, whereas understanding illness presupposes an understanding of health. This is especially true of mental health which consists in a person's dynamic responses and adaptation to the realities of life. Mental health promotion aims to help people flourish, and when they are not able to cope, aims to help them to recover and to be resilient. It should not be defined only as the absence of mental disorder.[48]

It should also be said that, while human flourishing includes body, mind, and spirit, the goals of mental health and spiritual peace are not the same. A Christian desire to serve others may disturb someone's peace of mind and the lives of the saints show that it is possible to be holy, and close to God, even when suffering both physically and mentally. Mental health is therefore not itself the ultimate aim of human life, and integral ecology must also include moral integrity and the freedom to find spiritual and religious meaning. Nevertheless, the public health perspective on mental health is an important aspect of an authentic human ecology. The EU approach to mental health as a public health issue, emerging from the respective responsibilities in the EU Treaty, helps point to an important truth about the human person.

c. Allocation of resources to mental health

The promotion of mental health and treatment and prevention of mental disorders raise issues of justice in the allocation of resources. It is evident from the overview at the beginning of this paper that mental illness constitutes a significant proportion of disability in Europe, whichever way this is measured. It is also evident that the implementation gap between need for services and provision of services is greater in relation to mental health than in physical health. People with mental health problems do not seem to get their fair share in the allocation of healthcare resources.

The reasons for this apparent injustice are complex and historical. In part it is the case that mental health problems have been seen as less serious than physical problems because they are not seen as life-threatening. This is to ignore the indirect impact of mental disorders on physical health and risk-taking behaviour, in addition to the increased vulnerability to suicide. It is also to ignore the seriousness of conditions - physical and mental - that do not shorten life but cause chronic and sometimes life-long disability.

48 For a theological definition along similar lines see Latin American Episcopal Council (CELAM) *Discípulos misioneros en el mundo de la salud. Guía de pastoral de la salud para América Latina y el Caribe*, Bogotá: CELAM, 2010, §§6-8.

It is also the case that mental illness is stigmatised and has sometimes been regarded as self-inflicted or due to some moral flaw such as laziness, self-centredness or disordered desire. It is true that a pattern of human behaviour, such as substance abuse, can lead to mental health problems. However, even where physical or mental problems are compounded by actions taken by the person, this should not be decisive to the just allocation of healthcare. Most ill health has some behavioural component and most people in good health have at some point indulged in risky behaviour.

The first consideration for just allocation of healthcare is provision according as each has need, including the general need for health promotion.[49] Catholic social teaching provides some tools to assist policy makers in the difficult task of just distribution of resources.[50] Catholic theology also offers a critique of unjust social arrangements, 'structures of sin', which have systematically marginalised certain groups.[51] It provides a basis to give preferential treatment precisely to those who are likely to be the subjects of prejudice or stigmatisation, including prisoners, refugees,[52] migrants, the socially deprived and those with mental health problems. The voice of the Church is a potential ally to policy makers in seeking to overcome the interests of majorities and of articulate minorities in order to promote wider promotion of the goods of physical and mental health.

d. Autonomy and treatment decisions

The primary responsibility for an adult's health lies with that person, and therefore, where the patient is competent, 'the primary responsibility for deciding whether treatment should be given or not rests with the patient.'[53] The right to decide on matters of health, and the need for a doctor to obtain consent before providing treatment, are based on a person's duty to care for their own health. Sometimes mental disturbance will prevent someone from being able to make rational decisions. However, even the presence of mental illness does not usually remove

49 Fisher, A. and L. Gormally, 2001. *Healthcare Allocation: An Ethical Framework for Public Policy.* London: Linacre Centre.

50 See for example, Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church*, 2004, §§ 355, 358, 412 or 438. D.A Jones, A. Beck and P. Gately *Healthcare Allocation and Justice: Applying Catholic Social Teaching* London: CTS, 2010.

51 Pope John Paul II, *Sollicitudo Rei Socialis*, §36.

52 European Parliament, The public and health dimension of the European migrant crisis, 2016, p. 3 http://www.europarl.europa.eu/RegData/etudes/BRIE/2016/573908/EPRS_BRI%282016%29573908_EN.pdf.

53 Catholic Bishops' Conference of England and Wales. *Cherishing Life*. London: CTS, 2004, §156, http://www.bioethics.org.uk/images/user/cherishing-life-2004.pdf.

totally 'the moral obligation of the patient to pursue the truth and to grow in virtue'.[54] To think so would be to fail to respect the dignity of the person. For this reason, the Church supports the right of patients to refuse treatment and holds that compulsory treatment must be exceptional - and a last resort when alternatives such as 'shared decision making' or 'assisted autonomy' have proven unattainable - and when authorised by the family[55] and subject to legal safeguards.

In other words, the duty of the doctor not to act without the consent of the patient and the patient's right to participate in the decision regarding the treatment arise primarily from the recognition of the dignity of the person, that is to say, respect for autonomy is based on respect for the dignity of the person.[56] The patient is 'a responsible person; and must be called to take part in improving their health and obtaining healing; he should be put in a position to choose personally and not have to accept decisions and choices of others'.[57] Nevertheless, the Church understands persons always in relationship with other persons, and understands autonomy also in a relational way. Thus in deciding whether to provide treatment, doctors must make their own independent assessment as what would be beneficial for the patient. A doctor should not provide an intervention which would be harmful, even if requested, but where doctor and patient differ as to what is best, the doctor must listen to the reasons for the request. It may be that a doctor underestimates the significance of some benefit for a particular patient, or overestimates the burden of treatment in their case. In this sense, one may say that autonomy is a way of

54 Pope John Paul II. Address to the Members of the American Psychiatric Association and the World Psychiatric Association, 4 January 1993, http://w2.vatican.va/content/john-paul-ii/en/speeches/1993/january/documents/hf_jp-ii_spe_19930104_psychiatric-association.html.

55 The family members who are closer to the patient, providing care and support, which is frequently called 'the healthcare proxy'.

56 It is opportune to recall here that 'human life is sacred because from its beginning it involves 'the creative action of God' and it remains forever in a special relationship with the Creator, who is its sole end. God alone is the Lord of life from its beginning until its end: no one can, in any circumstance, claim for himself the right to destroy directly an innocent human being' (Congregation for the Doctrine of the Faith, *Donum Vitae*, Introduction, §5).

57 Address of John Paul II to the participants in the XV Congress of the International Federation of Catholic Medical Associations, 3 October, 1982, http://w2.vatican.va/content/john-paul-ii/es/speeches/1982/october/documents/hf_jp-ii_spe_19821003_medici-cattolici.html (in Spanish; and also in Italian and Portuguese). Already in 1957, Pope Pius XII held that position, though using different terms: 'The rights and duties of the doctor are correlative to those of the patient. The doctor, in fact, has no separate or independent right in relation to the patient,; in general, he can act only if the patient explicitly or implicitly authorizes it (directly or indirectly)' (Discours du pape Pie XII en réponse à trois questions de morale médicale sur la reanimation, 24 November 1957, http://w2.vatican.va/content/pius-xii/fr/speeches/1957/documents/hf_p-xii_spe_19571124_rianimazione.html (in French; and also in Spanish).

revealing what is beneficial to a patient, in the light of the principle of totality. Human life, whatever its state of fullness or deterioration, is always personal, and therefore inseparably enjoys the indivisible dignity, unitary reality of body and spirit.[58]

Because mental illness can affect someone's ability to make decisions, it may be that someone who refuses treatment is limiting their own freedom. If someone cannot be persuaded to accept treatment and if there is good reason to think that medical treatment would help that person to make a more rational decision, then this can provide ethical justification for compulsory treatment. However, such compulsory treatment must be time-limited and supported by the family and the legal authority. For similar reasons it would be ethical to override a refusal of treatment where this was clearly suicidal, for example, a refusal of treatment after a suicide attempt, but this would also require support by the family and sanction by a legitimate authority. In the case of longer term detention or ongoing compulsory treatment such authorisation would only be justified where a patient posed a serious risk to his own or other's lives or physical integrity. Societal wisdom and respect for fundamental human rights would require that longer term detention decisions were regularly subjected to reassessment and support by legal authority.

Another consequence of the relational character of persons is that decisions concerning healthcare should seek to include carers and others close to the person. A doctor has a duty of confidentiality to his or her patient, but this will already include many healthcare professionals and it should seek to include others who provide care and support to the patient, where the patient agrees to this[59]. Relationships are complex and patients should be given opportunity to make decisions on their own without pressure from others. However, it is a mistake to think that coming to a decision with the help of others is coming to a less autonomous decision. Here we are faced with the sensitive distinction between providing information, counselling or more paternalistically try to persuade or even put pressure on a patient's decision. Nevertheless, talking things through is, in general, a better way to make decisions, especially if the decision will affect others. Where people do not speak openly with those close to them then they may

58 Spanish Bishops Conference, Committee for the Defense of Life, *Euthanasia. 100 questions and answers on the defense of life and attitude of Catholics*, 1993, §75, http://www.conferenciaepiscopal.nom.es/ceas/documentos/eutanasia.htm (in Spanish).

59 The information given to other professionals and to third persons must be limited to that information related to the illness that is needed for treatment and for medical decisions. The healthcare professional must respect the privacy and intimacy of the patient, which is rooted on human dignity. This is the basis for a trustful doctor-patient relationship, which may be of particular relevance in the case of mental health.

mistakenly impute beliefs or fears to one another. This danger is especially great in the context of mental health problems where a person may underestimate their own worth or overestimate the burdensomeness to others of their care.

3. FIVE PRIORITIES FOR ACTION ON MENTAL HEALTH

3.1.1. Prevention of depression and suicide

In relation to depression, Pope John Paul II acknowledged that this 'is always a spiritual trial.'[60] Yet even in the midst of suffering God is present and depressive illness 'can be a way to discover other aspects of oneself and new forms of encounter with God.'[61] The role of those who accompany or care for depressed persons consists, above all, 'in helping them to rediscover their self-esteem, confidence in their own abilities, interest in the future, the desire to live.'[62]

The Catholic Church teaches clearly that suicide is contrary to a proper love of self and is harmful to others and to society as a whole. In its deepest reality, 'suicide represents a rejection of God's absolute sovereignty over life and death.'[63] However, the Church is increasingly aware of that 'psychological disturbances, anguish, or grave fear of hardship, suffering, or torture'[64] can lessen or remove subjective responsibility for the act. Thus 'attempting suicide is typically the act of a desperate person and it should be greeted with compassion rather than with blame.'[65] In particular, suicide is not a reason to despair of someone's the eternal salvation. 'By ways known to him alone, God can provide the opportunity for salutary repentance.'[66] For this reason the Church 'prays for persons who have taken their own lives.'[67]

A public health perspective on suicide focuses on prevention. There are some well-

60 Pope John Paul II Address to The 18th International Conference of the Pontifical Council for Health Pastoral Care. On 'Depression', 14 November 2003, §3, https://w2.vatican.va/content/john-paul-ii/en/speeches/2003/november/documents/hf_jp-ii_spe_20031114_pc-hlthwork.html.

61 *Idem.*

62 *Ibidem.*

63 John Paul II *Evangelium Vitae*, §66.

64 Catechism of the Catholic Church, n. 2282.

65 Cherishing Life, §181.

66 Catechism of the Catholic Church, n. 2282.

67 *Idem*, n. 2283. Note that suicide is not listed in the Code of Canon Law as a valid reason to deprive someone of Christian burial (Canon 1184). Such a penalty can only apply if funeral rites could not be granted 'without public scandal to the faithful' (Canon 1184, §1, 3o). The only example of scandal given in the Catechism in relation to suicide is where this it is done 'with the intention of setting an example, especially to the young' (n. 2282).

known risk factors that increase a person's vulnerability to suicidal behaviour and there are also factors known to inhibit people from seeking the help they need.[68] Prevention strategies therefore focus on addressing these risk factors, for example by restricting access to means of suicide or by encouraging responsible reporting of suicide by the media.[69]

While suicide occurs in every country in the world, and across all age groups, it affects some groups more than others. Among 15 to 29 year olds, suicide is the second leading cause of death globally.[70] This group has its own specific needs and also presents opportunities for intervention through schools and through the use of the internet and social media. Suicide prevention in this group has rightly been a focus of EU-level activity.[71]

Another group with very high rates of suicide, in most countries higher even than youth suicide, is men over 70. This risk is increased if the person has a serious physical illness, if he lives alone, and if he is socially isolated. Whereas youth suicide is always regarded as a tragedy, and rightly so, an added danger for older and disabled people is that suicide may be regarded as more acceptable. One of the harmful consequences of the debate over physician assisted suicide is that it can give the impression that the lives of older and disabled people are less valuable and preventing suicides in this group is less of a priority. This is a particular danger in the reporting of cases of assisted suicide where the death is romanticised as a heroic response to crisis or adversity. Such reporting effectively 'normalizes' suicide for a group of people who are already vulnerable to discrimination and lack of self-esteem.

3.1.2. Ideas in society that increase risk of depression and suicide

In European societies, many people come to carry a very negative view of their lives and feel that they have neither value nor meaning. Such negative ideas[72] can

68 World Health Organization. *Preventing suicide: a global imperative*. WHO 2014, p. 8, http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf.

69 World Health Organization, 2008. *Preventing Suicide: A resource for media professionals*. Geneva: Department of Mental Health and Substance Use, WHO.

70 *WHO Preventing Suicide*, p. 3.

71 For example, C. Wasserman et al. 'Suicide prevention for youth – a mental health awareness program: lessons learned from the Saving and Empowering Young Lives in Europe (SEYLE) intervention study.' *BMC Public Health*. 2012;12:776. doi:10.1186/1471-2458-12-776.

72 We are indebted to Professor Stephan Claes for his identification of five harmful ideas that need to be challenged.

increase the risk of depression or suicide and hence a major social and public health problem arises. The Church can make significant contributions in such an area by helping to overcoming these negative judgments.

a. 'I am a failure'

Every society will have implicit or explicit standards of success and social status. Similarly, every culture or subculture will have its heroes and celebrities. These standards and examples can be inspirational where they are flexible enough to include the whole range of human circumstances. However, where social standards are perceived to make very specific demands (in relation to appearance, career, achievements, abilities etc.) or where these standards are based on competition (so that some must lose for others to win), then they risk communicating a sense of failure. This is a particular danger for young people who are seeking to establish their identities.

Christians are not immune from these dangers and can present the message of Gospel as simply another such standard to be pursued with the same dangerous perfectionism. However, there are elements of the Gospel message that can help resist this temptation.

One element, already mentioned, is the doctrine of the image of God that is present in every human being. Every human being is created by God with inherent dignity. This cannot be lost whatever we do or fail to do. A second element, perhaps even more important, is that all human successes are gifts from God and dependent on the help of others, and never simply individual achievements. Taking pride in individual success is pleasant but it is always vain and this is sometimes a hard lesson to learn. Jesus said of his mission that he came 'to seek and save the lost',[73] not to reward those who had been successful. From a Christian perspective human dignity or worth is based not only on the image of God present in each person by virtue of their creation but also in that each person is someone for whom Christ was willing to suffer and die out of love for that person and not based on their prior achievements.

b. 'I am useless'

As young people are endangered by false ideals that they cannot reach, older people are endangered by concepts of usefulness that are crude and utilitarian. This is a danger especially for those who identify contribution to society with economic productivity or successful career. For most people, working life has

73 Luke 19.10.

as its aim financial independence and the ability to support a family. Retirement takes away this role and also deprives the retiree of the status and the social life that came with a particular career.

Catholic thought includes a concept of the dignity of labour, and the importance of providing people with opportunities for meaningful and fulfilling employment.[74] Such employment should not only enable people to support themselves but also be sufficient to allow people to marry and provide for their families. However, it is also important for those in paid employment to establish a work/life balance which gives time for relationships outside work. It is also important that those who are earning money have respect for those in the family who contribute in other ways, and most fundamentally by their very presence within the family.

The Christian perspective also broadens what it means to be useful, what kinds of service people can offer one another in terms of prayer, advice, witness and the telling of the stories that enrich the community. For all these reasons, Pope John Paul II, in his letter to the elderly, written when he was himself getting on in years, assures them that 'The Church still needs you.'[75]

The idea that human value is measured by net economic contribution is very dangerous indeed and is one that needs constantly to be challenged. If it were true, then this would not only endanger older people but would destroy the very idea of human equality within the family and within society as a whole.

c. 'I am a burden to others'

As it is a mistake to reduce someone's human value to their economic utility so it is a mistake to make autonomy the defining characteristic of human life. As set out above, Catholic doctrine always understands persons in relationship to others and therefore understands the autonomy of the human person as a relational autonomy.

The idea of absolute autonomy is illusory as it implies that human beings find freedom only through independence from others. In reality human beings are always dependent on one another and find freedom only with the help of others. This is most evident when human beings are young and when they are sick but, even when they are at their most independent, people flourish only through relationships with others.

74 Pope John Paul II *Laborem exercens.*

75 Pope John Paul II letter to the elderly, 1 October 1999, 13, http://w2.vatican.va/content/john-paul-ii/en/letters/1999/documents/hf_jp-ii_let_01101999_elderly.html.

Aristotle thought that it was noble to be generous but shameful to receive generosity. But the Christian understanding of love begins with *being loved*.[76] Being cared for is an opportunity to receive love and then to love in return. This is a profoundly human thing.

d. 'Nobody cares for me, I am alone'

Social isolation and loneliness are predictive factors for depression and vulnerability to suicide. This follows from what has been said about the relational character of persons. Whereas the dignity of persons does not consist in social success, utility or independence, persons are created to be in relationship. There is a place for solitude in human life, and some people are more temperamentally attracted to solitude. However, in a Catholic understanding, even the hermit in his cell remains related to the larger community and is neither forgetful nor forgotten. In contrast, 'one of the deepest forms of poverty a person can experience is isolation.'[77]

The provision of professional services is not sufficient to answer the human need for contact and relationship. What is needed is the sustaining of contexts within which people can relate to one another so that they have people whom they can care about and who can care about them. One should not exaggerate the extent to which parish communities fulfil this ideal. Nevertheless, the Church remains an important source and sustainer of human communities and recognises that seedbeds of communal life are of great importance for a culture that promotes mental health and wellbeing. It is also a responsibility of the entire society to foster social ties and prevent isolation and loneliness of its most vulnerable members[78].

e. 'People should not suffer'

There is a caricature of Christianity as a religion that wishes to see people suffer. The central image of Christianity is a tortured man and Christianity has inspired countless men and women to die as martyrs. However, this caricature ignores the compassion with which Jesus healed the sick and comforted the afflicted. It

76 On the illuminating difference between Aristotle and Thomas Aquinas on this point see MacIntyre, A. 1999. *Dependent rational animals: why human beings need the virtues*. Peru, IL: Carus Publishing Company, p. 127.

77 Benedict XVI *Caritas in veritate*, §53.

78 Comité National pour la Bientraitance et les Droits des Personnes Agées et des Personnes Handicapées (CNBD), *Prévention du suicide chez les personnes âgées*, 2013, http://social-sante.gouv.fr/IMG/pdf/CNBD_Prevention_du_suicide_Propositions_081013.pdf (in French).

ignores the spirit of mercy which, through the ages, has been seen in the founding of hospitals, medical missions, nursing homes and hospices. This is in addition to the practical expression of Christian charity in areas such as education, peace, emergency relief and international development.

Suffering is to be relieved not romanticised. However, sometimes human beings must bear suffering if they are to act well. For example, sometimes friendship requires that a person accompany someone through a painful experience, even though this requires sharing that burden. Christianity does not promote suffering or see it as a good in itself, but Christian faith enables people to find meaning in suffering when it is an expression of love or solidarity in this way.

'Pain is inevitable in all human life, but we all have the clear idea that man aspires to happiness. Therefore to endeavor to mitigate pain is positive, but to make it absolute is absurd and impossible when the idea to eradicate pain becomes absolute good to which must be subordinated the rest of the noble purposes of human action. In every human life there are dimensions or facets that are not always consistent with each other when trying to give absolute value to each of them; every human being has the right to defend its own views, but if this right becomes an absolute value, he will probably end up being a dictator for others; every man craves his welfare, but if you put this dimension of his nature above all other considerations, he will become incapable of any manifestation of generosity.'[79]

Generally, it is possible to address physical sources of suffering, and this can and should be done, for example through adequate provision of palliative care for people who are dying. It is much harder to address existential suffering over grief, fear of decline, or uncertainty about the future. Such suffering is 'more complex and at the same time still more deeply rooted in humanity itself.'[80] It can be ameliorated by human support and understanding, but is 'less reachable by therapy'[81] and cannot be eradicated altogether. The Catholic ethical tradition mandates the provision of adequate pain relief and the treatment of symptoms such as anxiety and agitation, even if this might shorten life. However, Catholic theology places high value of human relationships and the importance of making peace with others and with God, and hence does not permit permanent sedation

79 Spanish Bishops Conference, Committee for the Defense of Life, *Euthanasia. 100 questions and answers on the defense of life and attitude of Catholics*, 1993, §15, http://www.conferenciaepiscopal.nom.es/ceas/documentos/eutanasia.htm (in Spanish).

80 John Paul II *Salvifici doloris*, §5.

81 *Idem*.

to unconsciousness except for very serious reason.[82]

The suffering caused by mental disorder, while real, does not justify the complete suppression of consciousness, and still less does it justify deliberately ending a person's life. Facilitating the suicide of people who suffer from depression or who have a personality disorder is a counsel of despair. Happily, such practices remain illegal in most European countries. However, in those European countries that have legalised euthanasia it seems to be increasingly common for physicians intentionally to provide mentally ill people with the means to end their own lives.[83] These practices constitute a grave injustice to vulnerable patients and stand in direct contradiction of the EU priority to prevent depression and suicide.

3.2. Mental health in youth and education

Mental health among young people was identified as a priority for a number of reasons, principally because 'the foundation of life-long mental health is laid in the early years.'[84] Up to 50% of mental disorders have their onset during adolescence. It also seemed in 2008, and still seems in 2016, that there is a significant unmet need for provision of specialist mental health services for children and young people.[85]

The EU Pact highlights the need to engage with young people in schools and also the need to support parents. It recognises the vital need to safeguard young people from early trauma in the school environment or in the home.

The Church has a contribution to make in this area through its work in education and more broadly through its understanding of education and the role of the family. The parents are the first educators of the child and formal school education is always ancillary to the parents. Concern for the child's health and wellbeing

82 *Opinion of the Working Group On Ethics in Research and Medicine On Palliative Care in the European Union* COMECE 2016, p. 14 Speech of Pope Pius XII replying to three religious and moral questions relating to pain management, 24 February 1957, https://w2.vatican.va/content/pius-xii/fr/speeches/1957/documents/hf_p-xii_spe_19570224_anestesiologia.html.

83 L. Thienpont et al. 'Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study.' *British Medical Journal* (BMJ Open), 2015:5: doi: 10.1136/bmjopen-2014-007454; Kim SY, De Vries RG, Peteet JR. 'Euthanasia and Assisted Suicide of Patients with Psychiatric Disorders in the Netherlands 2011 to 2014.' *JAMA Psychiatry*. 2016 Feb 10. doi: 10.1001/jamapsychiatry.2015.2887; Appelbaum PS. 'Physician-Assisted Death for Patients with Mental Disorders—Reasons for Concern.' *JAMA Psychiatry*. 2016 Feb 10. doi:10.1001/jamapsychiatry.2015.2890.

84 *European Pact for Mental Health and Well-Being*, p. 4.

85 *European Framework for Action on Mental Health and Wellbeing*, January 2016, p. 5.

therefore requires good communication between school and parents so both are working together.

The EU Pact identifies support for parenting skills as a possible intervention to help safeguard the child. Without prejudice to this, from the perspective of Catholic social teaching, the Pact could have developed further the importance of a public health perspective on the family, rather than seeing the child in relative isolation. Sustaining an authentic human ecology involves considering those factors that sustain, or that undermine, the stability of the family.[86] For, the flourishing of healthy relationships requires the flourishing of families. These factors will include economic, cultural and legal aspects.

With special relevance as regards the youth, one should also highlight here that addiction and substance abuse adversely affect mental health. EU policy on mental health should therefore be closely related and coordinated with the EU policy on illicit drugs and on promoting healthy lifestyles, special its strategy for preventing substance abuse and addictions (drugs, alcohol, etc).

While there are undoubtedly young people who fail to obtain the services they need, because the need was not identified, people rightly have concerns about initiatives to screen for mental disorders in children. If a child is misdiagnosed with a disorder then this could be harmful and lead to over-medicalisation and stigma. These dangers are greater if a medical label, such as autism or ADHD (Attention deficit hyperactivity disorder), is required to access funding or educational support. Such concerns are not a reason for inaction but they are reasons to focus on conditions that are more readily identifiable and interventions that are known to be effective, and on implementing a system of review. Here as in other aspects the health of the child will be best safeguarded if parents are included as far as possible in communication and decision making.

3.3. Mental health in workplace settings

In relation to depression, mention has already been made of Catholic social teaching on the importance of work and of finding a work / private and family life balance. Systems that prevent and address bullying behaviour are as important in the workplace as they are in the school environment.
In general work is protective of mental health and those in work have a lower overall

86 See *Charter of the Rights of the Family* 22 October 1983, http://www.vatican.va/roman_curia/pontifical_councils/family/documents/rc_pc_family_doc_19831022_family-rights_en.html.

incidence of mental disorder compared to those who are unemployed or who are retired. Nevertheless, what was said of religion and the family also holds of work: that something that is good in itself can become the means or occasion of harm. Where workers are given tasks that are unclear and difficult or even impossible to fulfil, or where there is a high level of conflict and competing demands, or where the work seems to have no point or benefit, other than providing an income, then work can have a detrimental effect on mental health.

Linked with the phenomenon of 'burnout', modern organisations can engender or exacerbate stress and moral harassment in the workplace, which can be defined as 'a conduct which has the purpose or effect of violating a person's dignity and creating an intimidating, hostile, degrading, humiliating or offensive environment for the person'.[87] All employers have a moral obligation to seek to prevent such behavior in the workplace, and this obligation should take a legal form in all EU Member States.

Bearing in mind the stigma associated with mental illness, the higher social status of someone in work can inhibit the person from seeking help. This may be because someone is concerned about losing their job or harming their career prospects, but it can also be due to misplaced pride. Such a problem can affect the medical profession and also those who are professionally religious. It can be easier for someone to help another person's problem than admit they have a problem themselves. Creating a supportive human ecology in the workplace involves providing means to help professionals and carers recognise and address their own needs.

3.4. Mental health of older people

Addressing the mental health needs of older people is important for the prevention depression and suicide. However, it is also necessary to understand this task from the perspective of promoting health and not only of preventing disorder.
It should be a matter for celebration that medical science has enabled citizens in European countries to enjoy more years of retirement, including more years of healthy and active retirement. This extension of life has provided people with opportunities to explore new subjects or places and patterns of life that are not constrained by full time paid employment. Of course the extent of these opportunities depends on people's economic situation, and older people are often disadvantaged. A flourishing life in later years is also dependent on family and social relationships, and whether people are involved in local, parish or other

87 http://www.citizensinformation.ie/en/employment/equality_in_work/harassment_at_work.html.

forms of community that help sustain such relationships. It is for this reason that the EU Pact in relation to the mental health of older people begins with the aim of promoting 'active participation of older people in community life, including the promotion of their physical activity and educational opportunities'.[88]

When physical health declines or when people experience progressive mental impairment then the pattern of these activities and this participation may change. A person's need for care may present practical and emotional challenges not only to the person but to family members and those close to a person. Like all significant changes of life these may cause a level of stress with which it is difficult to cope.

It is thus within an already anxious and uncertain environment that people may be called upon to make difficult decisions in relation to planning their future care and in relation to palliative care. Reflection on decision making at the end of life should take full account of this context and the person's need for human support.[89]

3.5. Combating stigma and social exclusion

The starting point for Catholic ethical reflection on mental health is the dignity of the human person, a dignity that is inherent and cannot be lost through physical or mental impairment.[90] The stigma that is applied to people with a mental illness contradicts a fundamental principle of ethics. It fails to acknowledge any person as having equal dignity.

88 *European Pact for Mental Health and Well-Being*, p. 5. See also: *Prévention du suicide chez les personnes âgées*, op. cit.; Marco Trabucchi, "The Meaning of Social Solidarity amidst the Elderly in the Terminal Stages of Life", in : Pontifical Academy for Life, *Assisting the Elderly and Palliative Care* (Ignacio Carrasco de Paula and Renzo Pegoraro ed.), 2015, pages 235-242; and Address of his Holiness Pope Francis to participants in the plenary of the Pontifical Academy for Life, 5 March 2015, http://w2.vatican.va/content/francesco/en/speeches/2015/march/documents/papa-francesco_20150305_pontificia-accademia-vita.html.

89 On the ethics of end of life care see COMECE *Opinion of the Working Group On Ethics in Research and Medicine On Palliative Care in the European Union*, COMECE, 2016, http://www.comece.eu/dl/uuomJKJKooNMJqx4KJK/PalliativeCARE_EN.pdf. See also Catholic Bishops' Conference of England & Wales, *A Practical Guide to the Spiritual Care of the Dying Person*, London: Catholic Truth Society, 2010, http://www.catholic-ew.org.uk/Home/News/2010/CatholicBishops-Conference-launches-A-Practical-Guide-to-the-Spiritual-Care-of-the-Dying-Person.

90 'Mentally ill people retain their dignity, and the Church must welcome them' (Spanish Bishops Conference, *Religious assistance in hospital. Pastoral guidelines*, 1987, §100, http://www.conferenciaepiscopal.es/wp-content/uploads/2016/03/ARH.-Orientaciones.pdf (in Spanish)).

Stigma is a mechanism of social exclusion based on an attitude of discrimination. To stigmatise someone is to identify them as a member of a group that is not fully accepted in society. Where membership of a stigmatised group is not obvious, people will tend to hide that aspect of their identity so as to 'pass' as normal. Hence social stigma inhibits people from openly seeking help. It may also inhibit someone from seeking help privately, as even this would require acknowledging the stigmatised identity, if only to themselves.

Not only is mental illness itself subject to stigma but many of the circumstances that can induce or exacerbate mental problems are themselves stigmatised. The stigma of mental illness reinforces stigma someone may already face due to unemployment, migration, previous criminal behaviour, substance abuse, physical disability or old age. Not long ago, the mentally ill were admitted and cared for only in psychiatric hospitals; nowadays, they are also admitted in general hospitals.[91] Not only does this stigma inhibit recovery but stigma and prejudice themselves impose a mental health burden and cause significant avoidable morbidity.

As stigma involves both a social mechanism and a discriminatory attitude it needs to be tackled both by social action and changing ways of thinking. Christians will reflect many of the prejudices of their age and society, but there are resources within the Church to help Christians address stigma. The theme of inclusion is very prominent in the Gospel story. Indeed, this theme is fundamental to the message that Jesus died for gentiles as well as Jews, and that gentiles are now invited to share in the promise of salvation. It is a recurrent feature of Christian history for leaders and charismatic individuals to challenge the patterns of stigma of their own age.

In relation to mental illness this implies both reiterating the message that those suffering from mental illness are always in the image of God, and also finding practical ways for people with mental illness to participate fully within the society and Church community. One powerful way to confront stigma is for people in positions of responsibility to acknowledge their identity. Pope John Paul II reminded the Church that people in all states of life, including those living under religious vows, may be confronted by 'personal factors such as physical or mental illness, spiritual aridity, deaths, difficulties in interpersonal relations, strong temptations, crises of faith or identity, or feelings of uselessness.'[92] In some cases, these factors

91 *Idem*, §99.

92 Pope John Paul II Post-Synodal Apostolic Exhortation *Vita Consecrata* 25 March 1996, para 70, http://w2.vatican.va/content/john-paul-ii/en/apost_exhortations/documents/hf_jp-ii_exh_25031996_vita-consecrata.html

could lead to a period of mental illness, but there need be no shame in that. It does not imply any lack of virtue. Indeed, there is a real virtue for someone who visibly represents the Church, to speak openly if they have suffered from mental ill health. Only by such courageous actions will this stigma gradually be overcome.

4. CONCLUSION

'Mental disorders and suicide cause immense suffering for individuals, families and communities, and mental disorders are major cause of disability. They put pressure on health, educational, economic, labour market and social welfare systems across the EU'.[93] They are therefore a major cause of social and public health problems. Any policy in this field, to be effective, requires the collaboration of health professionals and families and friends of people with or at risk of mental illness, and also of all those with responsibilities in the health and political domains. The Catholic Church, for its part, considers that its mission includes the welcome within its communities of people with mental illness and their support, and the constant reminder that, however serious it may be, the disease does not detract from human dignity, but instead calls for special attention and care.

93 *European Pact for Mental Health and Well-Being*, 2008, p. 2.

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