

TO LIVE LIFE TO THE FULL

MENTAL HEALTH IN AUSTRALIA TODAY

S O C I A L J U S T I C E S T A T E M E N T 2 0 2 0 – 2 1



Australian Catholic Bishops Conference

FOREWORD

C OVID-19 pandemic is a threat in many ways – physical, social, political and economic. But it's also putting pressure on the mental health of many people in ways both seen and unseen. Those who are at high risk, and those who love them, may be especially anxious.

The loss of jobs and income from businesses, together with underemployment and insecure work, place enormous pressure on people trying to provide for themselves and their families. Isolation has also been very difficult for many – and dangerous for those who are in situations of family strife and domestic violence. These can be stressful times for people in decision-making positions. It's not easy to balance care for public health and safety and the need for social connection, economic activity and other essential communal activities – including public worship. Many of us will experience a mental health problem at some point through our lives – and this may well be the time.

In this Social Justice Statement, *To Live Life to the Full: Mental Health in Australia Today*, the Catholic Bishops of Australia encourage faith communities, governments and each one of us, to make mental health a priority.

We want to say clearly that mental ill-health is not a moral failure, the result of a lack of faith, or of weak will. Jesus himself was labelled mad (Mark 3:21; John 10:19) and, like us, he suffered psychological distress (Luke 22:44; Matt 26:37; Mark 14:33; John 12:27). People experiencing mental ill-health are not some 'other' people, they are 'us'. People in our families, faith communities, workplaces and society are suffering mental ill-health – and they can be of any age or socio-economic background. Whoever and whatever they

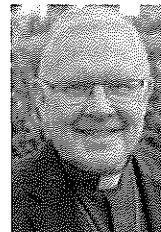
are, they need our understanding and support.

We commend the mental health support provided by volunteers and staff of Catholic organisations, hospitals, schools, and community health services, and we encourage you to reach out to them if you or your loved ones need support.

We know too that there are gaps in the mental health system that need to be addressed. Social determinants including poverty, living conditions, and personal security are significant contributors to mental ill-health. They place people who are already vulnerable or disadvantaged at greater risk of ill-health and of falling through gaps in the system.

During this time of pandemic, we have often heard it said that "we are all in this together". The quality of our care for the people who are the most vulnerable or disadvantaged will be the test of whether or not this is true. A commitment to the common good means attending to the good of all of us, without exception. It means paying special attention to those who are most often overlooked, sidelined or excluded.

It is surely time for us to make mental health a real priority, so that all people may know the fullness of life which Jesus offers (John 10:10).



+ Mark Coleridge

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Australian Catholic Bishops Conference

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TO LIVE LIFE TO THE FULL

MENTAL HEALTH IN AUSTRALIA TODAY

What does your mental health mean to you?

It can mean different things to different people and our views about it can change as we progress through life. The World Health Organisation defines mental health as:

... a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.¹

Mental health is not simply the absence of illnesses, but having the capacity and opportunity to thrive – that is, to participate in the fullness of life to which Jesus invites us (Jn 10:10). We are a unity of body, mind and spirit. The abundant life to which we are invited engages our whole selves, physically, psychologically and spiritually. It touches all aspects of our life together in community – social, economic and cultural – because God created us out of love and for loving relationships.

We are social beings. We need the bonds of family, friends and the broader community to celebrate the joys and hopes of life. These bonds help us to face

the usual challenges of life, but they are even more important in times of anxiety or despair.

We need the economic means to meet the costs of living, to develop our potential through opportunities to study, to pursue our personal callings through our work, and to plan for the future. A just economy ensures we can contribute to and share in the benefits of our society's common wealth.

Through culture we make sense of the world and hold up shared values such as a 'fair go' and lending a helping hand to others in difficult times. A healthy and sustainable culture breaks through the material entrapments of consumerism and limitations of self-interest.

As creatures made in the image and likeness of God we stand before the mystery of The Transcendent. We feel deeply connected to something, and indeed Someone, beyond ourselves. These bonds of loving relationship to one another, to all of creation, and to the Creator of all that is, help us to experience meaning in life, even in its sufferings and limitations.

These are key ingredients for good health in body, mind and spirit. They point to the quality of personal and social relationships that promote the fullness of life for all.



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THE MENTAL HEALTH OF OUR PEOPLE AND COMMUNITIES

Most of us will experience a mental health problem at some point over the course of our lives. These problems may be temporary, but they can develop into mental illness. It is estimated that just under a quarter of the population are at risk of experiencing a mental illness.

Mental health can be seen as a continuum. At one end are people who are feeling well and coping with the demands of daily life. This is the case for 60 per cent of all Australians.

At the other end are people experiencing mental illness. Common conditions include anxiety and depression. Others relate to psychosis, including schizophrenia and bipolar affective disorder. These can range from mild conditions that are self-managed, to those that need basic care, through to moderate and severe conditions that require specialist support or hospitalisation.²

With proper treatment and care, most people recover completely. And while those who are living with mental ill-health, or who are on the path to recovery, are often active and productive members of the community, significant challenges remain.

People experiencing mental ill-health often encounter stigma and may fall through gaps in medical and community care. In fact, mental ill-health through the lifespan is quickly becoming the greatest cause of disability in the world. Having an understanding of mental health can raise our awareness of people in our families, faith communities, workplaces and society who need our support.

Young people

In the lead up to the 2018 Synod in Rome on young people, we surveyed over 15,000 young

people in Australia. The National Report, *Called to the Fullness of Life and Love*, identified mental health, followed by school or study, drugs and alcohol, and body image as the main issues facing young people today.³

Mental illness typically emerges in adolescence and early adulthood. Three-quarters of people who develop ill-health first experience its symptoms before they are 25 years old.⁴ This period of transition comes with significant changes in the functioning of the brain in addition to many other pressures.

"I remember the day when they told me I had schizophrenia. I didn't know much about it at the time. I just knew all the stereotypes surrounding it. I was thinking 'Does that mean I'm dangerous? Does it mean that they're going to lock me away?' They just said it like it was nothing. But for me it was this huge, life-altering thing." *Hannah – SANE Australia*⁵

There is the pressure to succeed at school, to start university or find work. Lack of affordable housing, significant debt early in life, and the 'gig economy' can cause huge pressures. This is a time in life when young people at risk can withdraw from family and friends, engage in risk-taking behaviours and form a reliance on drugs and alcohol.

We are deeply saddened that over 3,000 people are lost to suicide each year and that young people aged 15 to 24 years of age are most

vulnerable. This is a growing problem. It accounts for around one third of deaths among people in this age group, with around 90 per cent of victims experiencing mental ill-health.⁶

Older people

Older Australians, on the other hand, have the best mental health across the lifespan.⁷ With increased longevity and good overall health, older Australians are taking up new opportunities for leisure, family life, social engagement and continued employment.

For those in declining health with few social supports, however, the experience of social isolation can cause depression and exacerbate pre-existing mental health problems. Major changes increase distress – grief for deceased spouses and friends, limited finances, losing independence and moving into residential aged care.

“Depression was like being in a black hole and not being able to climb out. A feeling of hopelessness. Unable to do anything, unable to drive, unable to think clearly. A terrible feeling of being alone which was different from being lonely.” *Barbara – beyondblue*⁸

People aged over 75 receive some of the lowest levels of mental health care. Because depression is regarded as common among frail-aged people in aged care, it may be seen as ‘normal’ and individuals and their carers are less likely to identify and treat the illness.⁹

Family life

Viewing mental health across the life span, we are mindful of those stresses that have an impact on family life.

The birth of a child is a great joy, but for many parents it can also be a difficult time. Up to 20 per cent of women experience depression during pregnancy and following childbirth. Postnatal depression can have severe and prolonged effects on daily routines and the care of a child.¹⁰

We know that the increasing demands of work can deprive families of valuable time together. More and more workers are employed on a casual or contract basis, some working two or more jobs with irregular hours. These pressures can

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place terrible stress on relationships. Three million workers have mental ill-health or are caring for someone with mental ill-health. There are also over 450,000 people struggling on meagre income support who have mental ill-health or are their carers.¹¹

We are all aware of the mental and emotional impact of separation and divorce. The breakdown of a relationship is distressing for each partner and can have a lasting impact on children. An especially acute problem is the impact of domestic violence and abuse on women. They are the most likely to suffer mental ill-health, with far higher levels of trauma, anxiety, depression and suicidal thoughts than the general population.¹²

Communities and crises

Over the past year Australia has been facing tumultuous upheavals, unprecedented in our lifetimes.

Prolonged drought has hit rural communities, threatening livelihoods, straining local economies and eroding community networks. ‘Environment-related’ anxieties have led to resignation and loss of hope. Sadly, that loss of hope has seen some take their own lives. Suicide rates in rural and remote communities are 66 per cent higher than in major cities.¹³

The recent bushfires wiped out entire communities. Lives were lost, communities displaced, homes and businesses were destroyed. The greater frequency and intensity of weather-

AAP/Dan Himbrechts



related disasters amplify the impact climate change is having on mental health.

“The whole thing came through like an explosion, that’s the only way I can describe it, like a huge tornado. The air was just full of greasy, black smoke and embers, the wind was howling ... houses were just going up in flames ... But you can’t get over something like that and some people feel it more than others ... some people I know went through terrible trauma after it.” *Vida* ¹⁴

We now face the COVID-19 pandemic. In our vulnerability we realise that we are not in control. Our daily routines have been disrupted and over a million people have lost their jobs or been stood down. Our workplaces and churches have been closed and we have been forced to isolate ourselves from others.

Anxiety and fear of the unknown are normal psychological responses that can spur positive responses to protect ourselves and our communities. However, severe anxiety or depression can incapacitate us and fear of the unknown can become fear of our neighbour. The solidarity of our community can be damaged and those who are most vulnerable can be put in harm’s way.

The number of people experiencing or at risk of mental ill-health has increased during this period

of pandemic. Many more will be distressed or relive previous trauma through the impact the virus is having in their lives.

This time also provides opportunities for our society to act in a way that brings harmony and sustainability to all of life. Already the air is fresher and rivers are running clearer. Greenhouse gas emissions are falling and our ecological footprint is shrinking. Governments have moved responsibly to assist many who have been affected economically. Focusing on the essentials of life has reduced the force of consumerism in our lives, and we are finding new ways to work and maintain our social networks online. We are rediscovering the creativity of love in new ways.

We hope that our society’s shared experience of anxiety and distress will help us to remove the stigma and discrimination that has surrounded mental illness over the centuries.

The real cost of mental ill-health

The Productivity Commission estimates that the cost of mental ill-health and suicide is between \$43 and 51 billion each year and that there is an additional cost of \$130 billion per annum associated with diminished health and reduced life expectancy.¹⁵ These costs will increase as Australia responds to the pandemic.

But the real cost of mental illness is far more than economic. It is felt in the stigma and discrimination experienced by the most vulnerable – being labelled, shunned, denied support, or not even

being recognised. This denies a person's human dignity and their right to live life to the full. It is a rejection of the gifts that they have to offer and their membership in the Body of Christ.

"I feel that it is very important for people to be heard. I do not feel that people suffering with a mental illness should identify themselves by their mental illness. If the wider community could see the person suffering mental illness as a whole person, rather than just as their illness, perhaps those who are ill would not encounter so much stigma in their everyday lives." *Sandra – Mental Health Commission of NSW*¹⁶

The stigma associated with mental ill-health can be as debilitating as the symptoms of the illness.

Negative stereotyping of mental illness can have a huge impact socially. People are often avoided, excluded or experience dismissive treatment at community gatherings. Meanwhile, in the workplace people with mental ill-health can be judged incompetent and denied opportunities for advancement.¹⁷

Economically, people with mental ill-health face greater levels of discrimination when seeking employment, renting accommodation and purchasing insurance. One in four of the poorest 20 per cent of Australians experience high or very high levels of psychological distress compared with only one in ten in the highest income brackets.¹⁸

In the cultural sphere, we must question the way mental illness is understood and portrayed. Popular culture, films and advertising often ridicule people living with mental ill-health or cast them as being violent. Sensationalist media reports can perpetuate fear and prejudice. In fact, people with mental ill-health are no more violent than the general population and they are more likely to be the victims of violence and crime.¹⁹

Stigma undermines self-esteem, the treatment of ill-health, and the process of recovery. Tragically, people on the receiving end of prejudice and discrimination can internalise negative stereotypes and 'self-stigmatised'.

Members of the Body of Christ

Our society tends to draw away from, or to push away, those who confront us with our frailties and limitations. It is a dynamic that is completely at odds with the story of Jesus. In the Incarnation Jesus takes on the frailty of the human condition. He actively draws near to those who are sick or who have disabilities, those who are poor, marginalised or despised.

Through Jesus we have become members of one body.

People living with mental health challenges, are no less members of the Body of Christ than anyone else. People with mental illness and their families often feel isolated from their faith community and thus isolated from God. Isolation is often caused by social stigma: the idea that mental illness is a question of character or a punishment from God.²⁰

Our parishes, organisations and communities should be places of acceptance, care and healing, not places of rejection or judgement. Furthermore, as Pope Francis constantly reminds us, we have to take the initiative to go out to those pushed to the edges, rather than waiting for them to come to us seeking welcome.

All human beings have frailties and limitations because we are creatures and not 'gods'. Despite

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and even through these frailties and limitations, all of us are able to give glory to God and to share in Jesus' mission.

When we listen closely to the lived experience of people experiencing mental ill-health, we will most likely observe trouble or suffering, but we may also perceive intimate connection with God, flourishing, fruitfulness and life-giving action – signs of God's grace.²¹

Rather than shying away from human frailty, or seeing it simply as a problem to be solved through scientific knowledge, we need to attend carefully to it, seeking to discern God's self-communication and call. If mental illness is a unique form of frailty, it might also be a context in which God's strength is manifested in unique ways. By turning our faces from those of us who are suffering from mental illness, we refuse to learn what they have to teach us about God.²²

We are called to re-member the Body of Christ by making mental health a key priority, acknowledging people living with mental ill-health as 'us' and not 'them'.

As Bishops, we urge all parishes to make the issue of mental health a priority in their ministry of inclusion and pastoral care. In 2019 we issued mental illness and outreach guidelines for parishes through our Disability Projects Office.²³ Entitled *Do Not Be Afraid*, the guidelines highlight very practical steps we can all take, including:

- Increasing mental health awareness training,
- Making links with mental health networks in our local area,
- Advocating for the rights of individuals and their families,
- Encouraging peer-to-peer support.

Especially when people are experiencing great trauma in their lives, we have a role to maintain and develop relationships affording safety, trust and collaboration.²⁴

Members of our community with the lived experience of mental ill-health have much to offer in informing our ministry, and the opportunity for peer support shows how mental health and well-being can be fostered in everyone's lives.

"If you're struggling, don't be afraid to get help. No matter how small you feel the issue is in your head. Although you may feel right now like things aren't as good as they should be, they will get better. I've been there, a lot of us have been there. You don't have to feel alone." *Declan – SANE Australia* ²⁵

Jesus himself was labelled mad (Mk 3:21; Jn 10:19) and like us he suffered psychological distress (Lk 22:44; Mt 26:37; Mk 14:33; Jn 12:27). If Jesus embraced these human experiences, can we not welcome and value those who are living through them today?

THE GREAT PROJECT OF COMMUNITY INTEGRATION

Through the middle ages and even up to the 18th century, the treatment of people with mental illness included public shaming, inquisition, banishment, incarceration, torture and execution. The false view that 'madness' was the result of demonic possession, immorality or a punishment by God played a part in this history.

The life of St John of God (1495–1550) provides an example. St John devoted his life to the care of the sick and destitute and himself experienced times of great mental and spiritual anguish. He was subjected to 'the latest methods to try to bring him to his senses':

The cures they used for such cases like his consisted of flogging and placing the afflicted person into a dismal dungeon. They used other similar methods as well, so that by means of inflicting pain and punishment, the patients might shed their madness and regain their sanity. So they stripped him naked and tying him up by the hands and feet, they flayed him with a doubly knotted whip.²⁶

In his ministry to people experiencing mental illness and destitution, St John established a hospital in Granada – the House of God – where people were treated instead with charity and love.

The development of the sciences of psychology and psychiatry in the 19th and 20th centuries recast the issue of mental health as a medical one. Asylums for the 'insane' were established to treat people in a secure environment away from the mainstream of society. Psychiatrists began to develop standards for the diagnosis of disorders. Psychological therapy and advancements in medications led to an approach in which the

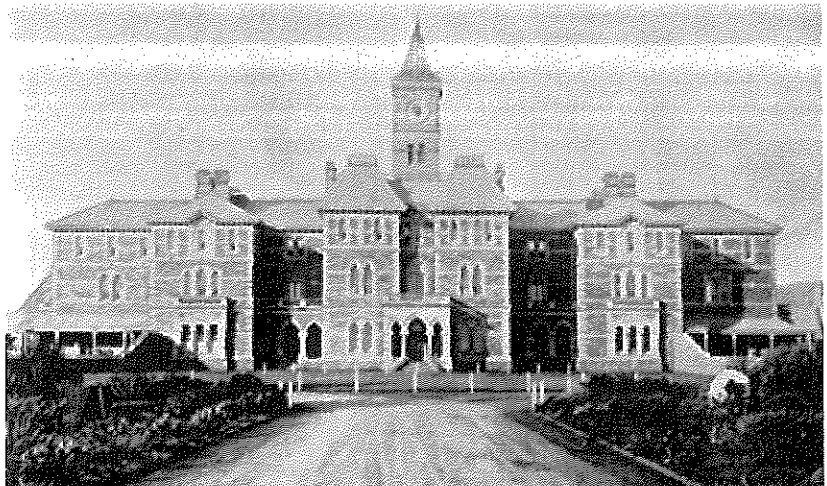
treatment of ill-health sought an end to long-term institutionalisation and promoted the release of patients back into society when they were well.

But mental hospitals were often overcrowded, and patients were exposed to inhumane and abusive conditions, often indefinitely. Hence the asylum model gave way to less custodial and less segregating community-based care.²⁷

The program of 'deinstitutionalisation'

In the late twentieth century, Australia began closing its mental health hospitals and reintegrating people into the community to receive medical and psychosocial support. This process

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reduced the number of acute psychiatric beds from 30,000 in the 1960s to around 6,000 by 2005.²⁸

In the early 1980s, the New South Wales Inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled ('The Richmond Report') became the blueprint for the new model of care.

Integrated community services, backed up by specialist hospitals, were to ensure that people living with mental ill-health were cared for in a 'normal community environment'. Early intervention, home-based care for people experiencing mental illness and adequate support for their families were stressed. The aim was to foster a supportive community, where mental illness was de-stigmatised and the rights of people with ill-health to social integration and opportunities for advancement were guaranteed.

But there was a catch. The program would only work if it was preceded by the redirection of funding from the closure of existing hospitals to the development of community services.²⁹

A decade later, the National Inquiry into the Human Rights of People with Mental Illness ('Burdekin Report') found the policy had largely failed due to inadequate funding. Because of the inadequacy of community mental health services, charities and the community sector, together with families and carers, ended up carrying much of the load. Inquiry Chair and Human Rights Commissioner, Brian Burdekin, labelled the deprivation, discrimination and stigmatisation still suffered by Australians affected by mental illness 'a national disgrace'.³⁰

"Ten years ago we had far more community services in Central Sydney than we have now ... People have just been duded. The money has been syphoned off on the pretext of putting it into the community and then it goes into some black hole and it's never seen again." *Dr Jean Lennane (in 1994) – former director at Rozelle Hospital*³¹

Since then there have been many Federal and State inquiries, but they have not led to lasting reform. A National Mental Health Strategy has been established, and we now have the Fifth National Mental Health and Suicide Prevention Plan. The Productivity Commission has recently been conducting a national inquiry into Mental Health and Victoria is holding a Royal Commission into its mental health system.

The commitment of governments to the humanitarian principle of community integration was a great advance that is still to be fully realised. It is hoped that the current inquiries will ensure adequate funding for Australia's mental health system. We need a nationally agreed, implemented and evaluated mental health service model.

The missing middle

While Australia spends over \$10 billion on mental health care each year, we still have disjointed and complex service systems that are difficult to navigate. They are unresponsive to the needs of people experiencing a mental health crisis and lack capacity to provide a person-centred service across the continuum of care – ranging from consultation with general practitioners through to acute specialist care.³²

There is a 'missing middle' – a severe lack of specialist community mental health services and after-hours care. Gaps between primary health care and acute care mean that people are falling through the system.³³ They are the ones whose mental ill-health is too complex for general practitioners yet not severe enough to access limited specialist support.

People who have special needs also face barriers to accessing care and getting the correct diagnosis. For example, it is very difficult for people with disability, particularly intellectual disability, or those within the deaf community, to find appropriate services.

Access to care is limited where services in public health are stretched and care in the private system, particularly for those without insurance, is unaffordable. There has been a significant increase in people attending emergency departments, but these are often busy and ill-equipped to assist and turn people away or refer them to another hospital.³⁴ Patients are also at risk of being discharged prematurely from acute mental health units due to the limited number of beds.

“When I took that really, really difficult step, that really heartbreaking step of trying to ask for help, there was really nothing there for me. I was kind of greeted with silence in return. So, that’s just really distressing ... it makes you feel very hopeless and like you’re really never gonna get better.” *Amelia*³⁵

This is not a criticism of mental health staff. We commend the commitment and hard work of doctors, nurses, community care workers and volunteers who are often overstretched in their service to people who are vulnerable and distressed. They have faced pressures over many years as a result of rapid policy changes, increased demand, funding and staff shortages. The impact the National Disability Insurance Scheme will have on access to mental health services and on staffing and employment in the sector is also uncertain.

We commend the mental health support provided by volunteers and staff of Catholic organisations including the Society of St Vincent de Paul, CatholicCare, our hospitals, schools and community health services, and the wide-ranging work of Religious Orders. Catholics can be very proud of their efforts to bridge the ‘missing middle’.

Unsung heroes

The burden of this policy failure has been borne largely by informal carers – often family and mostly women. They have picked up many of the responsibilities once budgeted for and funded in the mental health institutions of last century. Over 970,000 Australians are caring for loved ones who experience mental ill-health. The cost of their care is valued at up to \$15 billion each year.³⁶

Personal fulfilment, companionship, a sense of service and devotion are all part of care-giving

in close relationships. However, the level of need and emotional and financial stress can also take their toll on these unsung heroes of Australia’s mental health system. Foregone employment opportunities, diminished social networks, and reduced income and savings are common experiences of people caring for someone with severe, complex and prolonged mental ill-health.

Carers are themselves experiencing high levels of psychological distress as a consequence. It has been estimated that carers experience clinical levels of depression at a rate over 75 per cent higher than the general population.³⁷

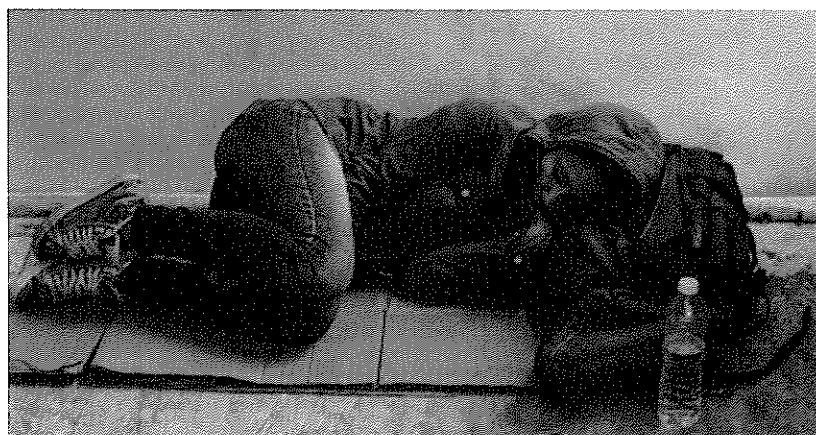
“We care because we love the people who need us, but caring takes a massive toll on our mental health! We give up plans, dreams, relationships, careers and much, much more – to give them the best life possible. We become isolated from our friends, relatives and co-workers because our lives are ‘different’ and no longer ‘fit in’ to mainstream, ‘normal’ society. I am one such carer. I care for my son who I love dearly but I spend my days ‘on edge’.” *Amy*³⁸

Falling through the system

The circumstances of people who are falling through the system demonstrate the mental health system’s failure to provide adequate community care. Two groups most vulnerable to mental ill-health are people who are homeless or in prison.

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People who are homeless experience a much higher incidence of mental ill-health than the general population – some estimate as high as 80 per cent.³⁹

Mental illness is both a cause and a consequence of homelessness. The inability to negotiate rental markets or the supported accommodation systems, with a lack of other community support, puts people at a high risk. And being homeless, living in poverty, with all of the uncertainties and fear of harm and violence is a cause of high levels of psychological distress.

“It does impact my mental health and my emotional wellbeing from time to time. It’s given me a general sense of fear. So, fear around losing a home, losing an income, not managing my life in that way, and the reality that the potential of homelessness could happen if things go wrong again ... The ignorance from the broader community is what impacts me the most. The emotional impact ... There’s still things I am working through emotionally ... the sense of guilt that my daughter had to go through that experience with me.” *Naomi*⁴⁰

The lack of secure and affordable accommodation is the greatest obstacle to treatment and recovery.⁴¹ People who have mental illness, and who have been in psychiatric hospitals or in transient accommodation, often lack living skills. They need ongoing support, at assessed levels, to be able to budget, buy food, cook, clean, maintain hygiene and link to community services. Otherwise they are unable to sustain tenancy and become homeless

again. The ‘Housing First’ model of housing and support has been proven worldwide to be effective in ending street homelessness, including for people with mental illness and also dual diagnosis of mental illness and substance abuse.

Without a home and the right support, the most vulnerable are caught in an ongoing cycle through homelessness services, boarding houses, emergency departments and acute care.

And then there is the risk of exposure to the criminal justice system.

Mental ill-health does not equate with criminality and violence. However, exposure to the criminal justice system does increase when adequate community supports just aren’t there and people experiencing extreme episodes become a danger to themselves or others, often on the streets. The police find themselves the ‘default first responders’ where services are unavailable, particularly after hours. Clearly, we need community mental health services that are accessible and mobile 24 hours a day.

“I know of someone who got themselves arrested just so they could get into acute mental health care. For some reason there was not a single bed in the state for this person, and the person had to sit in the emergency department with two police officers for 36 hours.” *Anonymous*⁴²

Around 40 per cent of people coming into prison and those being discharged back into the community have a previous diagnosis of mental illness. They are ten times more likely than the general population to report a history of suicide attempts and thoughts of suicide. One third of inmates reported being homeless in the month prior to incarceration and 54 per cent expected to be homeless on release.⁴³

The interplay of poor mental health, homelessness and incarceration demonstrates the failure of the mental health system to intervene early enough, and through the course of people’s lives, to support them in their families and communities. The poor implementation of community integration has seen the most vulnerable re-institutionalised in today’s boarding houses, shelters and prisons.

Those who have fallen through the system show us what is needed for a properly functioning system:

- A significant increase in funding that is quarantined and budgeted with independent oversight and public accountability,
- Coordinated person-centred care from early intervention to acute care and aftercare across clinical, community mental health and housing, social services and charities,
- Improved and prioritised services for people with serious, complex, enduring conditions,
- Improved mental health services, and the provision of face-to-face services where they are lacking, for rural and remote communities, Aboriginal and Torres Strait Islander communities, those of culturally and linguistically diverse backgrounds, and for people who are homeless or incarcerated,
- Improved professional support to carers who are unaided and isolated.⁴⁴

Without such a commitment, the system will continue to fail vulnerable people and the community as a whole.

Caring for the whole person-in-community

We do not believe that mental ill-health is caused by a moral failure or that it is a matter of character. Suffering from a psychiatric disorder or experiencing psychological distress is not a sign of a lack of faith or weak will. Throughout history we can see that people of strong faith and great holiness also experience mental health challenges. The account of Jesus' own distress and suffering in the garden at Gethsemane (Lk 22:44, Mt 26:37, Mk 14:33, Jn 12:27) makes it particularly difficult to sustain a claim that mental distress should not be part of the Christian life!

There are many accounts of psychological distress in the Bible. For example, at one point, Elijah is so despondent that he asks God to take his life (1 Kings 19:4), and Naomi is so distressed that she renames herself Mara or 'bitter' (Ruth 1:20). God's response to Elijah suggests an integrated approach to mental health. An angel appears to Elijah tending to the physical needs of his tired body and later God approaches Elijah gently in a whisper addressing the source of his despair. The story of Naomi and Ruth highlights the importance of social support in times of psychological distress. In neither case does God chastise the one who is suffering or coax them to pray more or to repent of sin!⁴⁵

The account of the Gerasene demoniac, who is living in a cemetery among the dead (Mt 8:28-34; Mk 5:1-17; Lk 8:26-37) and exhibiting behaviours that suggest mental ill-health, is a story of the dignity of the person-in-community. The man himself, while still ill, takes the initiative and runs towards Jesus (Mk 5:6-7). When he is cured, the man is restored not only to health, but also to community.

He is freed from the stigma of mental ill-health. Furthermore, he is invited to participate in Jesus' mission and becomes a witness. He is sent out to proclaim God's action in his life (Mk 5:19-20).

Some instances of mental illness may be explained and addressed by a purely medical approach. However a more holistic approach is often needed because human beings are a unity of body, mind and spirit, and we are persons-in-community. Mental ill-health, and the suffering that often accompanies it, may be as much a mystery to be lived as a problem to be solved.

Some suffering – including psychological suffering – can be meaningful, potentially transformative, and even redemptive. Not everyone who experiences mental illness will recover, but all nonetheless share in Jesus' promise of the fullness of life (Jn 10:10). If we seek only to cure, rather than to accompany people experiencing mental ill-health, we will be of no help to people seeking meaning in their experience. We will not notice the action of God in their lives or learn what they have to teach us.⁴⁶

It is precisely in the broken, powerless and despised that God most frequently speaks to us. Like all members of the Body of Christ, people experiencing mental ill-health are called to be witnesses in their own way.⁴⁷

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WE ARE ALL IN THIS TOGETHER

The test of our society's commitment to the common good is the care we show for the people who are most vulnerable or disadvantaged. Pope Francis explains in his encyclical *Laudato Si'*:

In the present condition of global society, where injustices abound and growing numbers of people are deprived of basic human rights and considered expendable, the principle of the common good immediately becomes, logically and inevitably, a summons to solidarity and a preferential option for the poorest of our brothers and sisters. This option entails recognising the implications of the universal destination of the world's goods ... it demands before all else an appreciation of the immense dignity of the poor in the light of our deepest convictions as believers.⁴⁸

A commitment to the common good means attending to the good of all of us, without exception, paying special attention to those who are most often overlooked, pushed aside, or fall through the gaps.

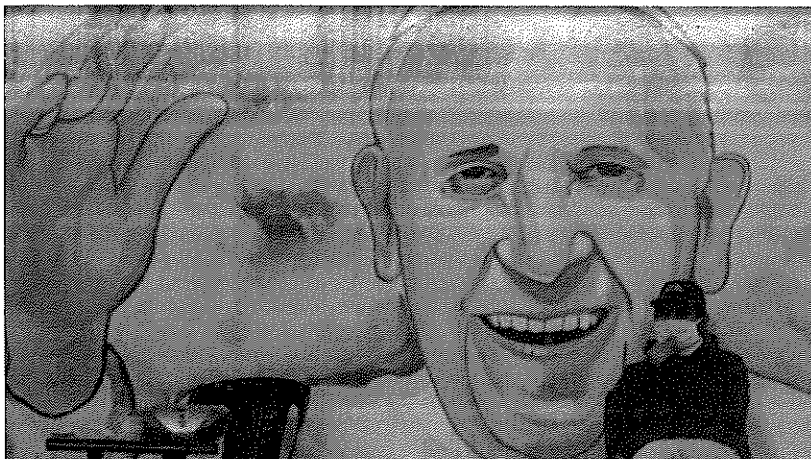
We know that social determinants including poverty, living conditions and personal security are significant contributors to mental ill-health. There is no doubt that these factors place First Nations people and communities, asylum seekers, refugees and humanitarian entrants at a disproportionate risk of poor mental health.

What is the quality of our care for these groups?
Are we really all in this together?

First Nations people and communities

Aboriginal and Torres Strait Islander people continue to be over-represented on key measures of disadvantage including lower life expectancy, poverty, imprisonment and ill-health, both physical and mental.

"Mental illness doesn't just affect the Aboriginal community, it affects everyone, but unfortunately it's even more prominent in our Aboriginal and Torres Strait Islander community. Depression and mental illness and suicide in Aboriginal communities is a huge flow on effect from things that happened 200 years ago. A lot of people don't like to hear that, but it is what it is. We've been oppressed for 200 years, knocked down to the point where many people start to develop these mental illnesses. We've got to help our community build their resilience and confidence." Joe Williams – Mental Health Commission of NSW⁴⁹



AA/PJuan Ignacio Roncoroni



AAP/Darren England

Social and economic disadvantage is a cause of higher levels of mental illness among our Indigenous sisters and brothers. Behind this disadvantage lies the history of dispossession, which is itself the cause of intergenerational trauma.

European settlement brought alcohol, diseases, poverty and new forms of violence. The destruction of physical and spiritual links to country has had disastrous impacts on identity, culture and language. Australia's history is marred by massacres, generations of children stolen, imprisonment and First Nations people pushed to the fringes.

The death rate from intentional self-harm is twice as high for Aboriginal and Torres Strait Islander people as for non-Indigenous Australians. This rate has increased dramatically over the past decade, from 17 to 24 in every 100,000 people.⁵⁰

Being incarcerated poses a risk of ill-health and self-harm. It is very alarming, therefore, that the imprisonment of Indigenous people is increasing – from around 7,500 to 10,500 over the past decade. First Nations people make up three per cent of the Australian population, but almost a third of people in prison.⁵¹

Clearly there is a pressing need for the development of collaborative and culturally appropriate mental health services. Better linkages with the criminal justice system are needed to promote diversion from custody.

Much more is needed too. In 2017, Indigenous Elders and leaders from around Australia gathered at Uluru for the Aboriginal and Torres Strait Islander Referendum Convention. They issued the *Statement from the Heart*, which emphasised the nation's need for greater truth-telling and Indigenous empowerment in decision-making:

Proportionally, we are the most incarcerated people on the planet. We are not an innately criminal people. Our children are alienated from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future.

These dimensions of our crisis tell plainly the structural nature of our problem. This is the torment of our powerlessness.⁵²

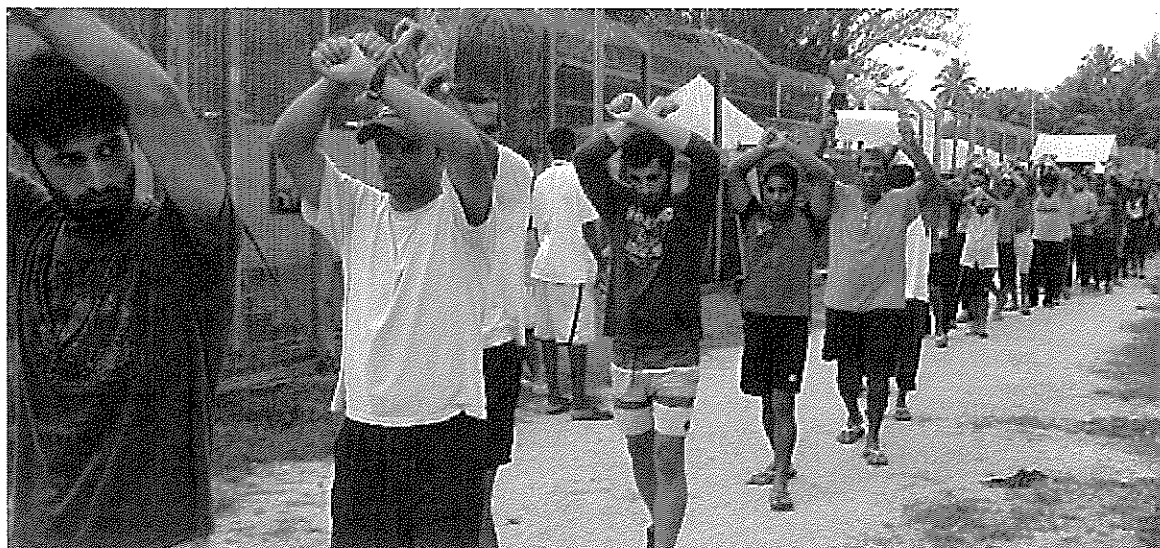
The *Statement from the Heart* calls for constitutional reforms to establish a First Nations Voice and Makarrata Commission to underpin agreement-making with government. The empowerment of an Indigenous voice and self-determination in all decisions that affect the lives of their communities is aimed at bringing the values of fairness, truth and justice to Australia's relationship with First Nations people and communities. It is about stepping up to the unfinished business of our past and ensuring the right of each person to flourish and live life to the full.

That call is yet to be answered in a spirit of national solidarity.

Refugees and asylum seekers

The common good is both universal and intergenerational because the human dignity of people does not depend on their location in time or space. As the COVID-19 pandemic has made painfully clear, we are one human family. We are called to loving relationships with all people regardless of nationality or visa status. A

AAP/PR Handout Image



commitment to the good of all, especially the most vulnerable, must include those people who have been locked in Australia's offshore immigration detention centres.

At the end of 2012, Australia resumed its offshore processing of asylum seekers, transferring people who arrived by boat to Nauru and Manus Island in Papua New Guinea. Over 4,000 men, women and children have passed through these centres since that time.

In September 2019, there were around 600 people still detained in Nauru and Papua New Guinea. It is estimated around 70–75 per cent have been determined to be refugees. Some have been in detention for up to seven years.⁵³

"Will I see freedom again?

My wings have become disabled in the cage of waiting.

The vision of my eyes can't see from behind
the grid fences any more.

Hope and love are dying in my body.

I have become a stranger with myself."

*Kazem – Manus Island*⁵⁴

Many immigration detainees already experience poor mental health as a result of the disasters and wars, persecution and torture from which they have fled. They experience high levels of depression, anxiety and post-traumatic stress. Fleeing entails the experience of great insecurity and involves many risks such as human trafficking and forced labour, harassment and abuse.

How is it that we as a nation have spent around \$1 billion a year to establish and run offshore detention centres that we know breach key international human rights obligations, including that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment?⁵⁵

Detaining people in inhumane conditions and refusing them resettlement in order to send a message to people traffickers treats vulnerable people as a means to an end. The damage done in the meantime has compounded their trauma and mental ill-health.⁵⁶ The policy seems aimed at breaking their spirits, but it does the rest of us spiritual harm too.

The deterioration of mental health in those held offshore is evident in extremely high levels of self-harm. Several people have died by suicide both in offshore detention facilities and facilities in Australia. People are cutting themselves, self-battering and attempting to hang themselves. The respective rates of self-harm on Nauru and Manus Island have been estimated as being 45 and 216 times the Australian rate for hospital treated self-harm.⁵⁷

"Living here is hard. The tension in here and the tension from home. Too much sad[ness] ... whenever I call home they ask when I will be released. I tell them Inshalla (God willing) ... Many people here are hurting themselves. Boys cutting hands, arms ... I was thinking about that." *Unaccompanied child – Christmas Island, 4 March 2014*⁵⁸

We are especially aware of the risk of self-harm, assaults and sexual abuse of children in such environments. The 2014 Australian Human Rights Commission report, *The Forgotten Children*, found that children were endangered by the violent environment of centres and their close confinement with adults suffering high levels of mental illness.

A third of parents with children in detention had moderate to severe mental ill-health and one third of children had mental health conditions serious enough to be referred for psychiatric treatment if they were in the Australian community.⁵⁹ A recent study of conditions on Nauru confirms the huge risks to children in detention.⁶⁰

National bodies representing psychiatrists, psychologists, doctors and other mental health professionals have repeatedly condemned the disastrous mental health impact of detention. We join their call for an end to prolonged inhumane detention and for the transfer of high-risk groups including children and people with mental ill-health to care in the Australian community.⁶¹

The marginalisation and incarceration experienced by the First Australians and also the latest people to come to Australia raise real questions about our commitment to the common good. We are called to reach out to these people at the fringes who have been ignored and harmed by our society. They too must share in the good of all of us. As Pope Francis explains:

[God] impels us constantly to set out anew, to pass beyond what is familiar, to the fringes and beyond. ... Unafraid of the fringes, he himself became a fringe (cf. Phil 2:6-8; Jn 1:14). So if we dare to go to the fringes, we will find him there; indeed, he is already there. Jesus is already there, in the hearts of our brothers and sisters, in their wounded flesh, in their troubles and in their profound desolation. He is already there.⁶²

Moving forward as Church and as a Society

We have seen that the causes of mental illness lie in the social, economic, political and cultural context as well as within the person. Poverty, discrimination, trauma and violence frequently result in or contribute to mental ill-health. There can be no doubt that the institutional harm done to the most vulnerable in Australia is an instance of structural sin. This harm is reflected in the mental health issues, such as intergenerational trauma, suffered by individual people, families and whole communities. Both the harm and the causes must be addressed.

We Bishops, as leaders in the Catholic Church in Australia, are painfully aware of the failings of so many Church people and entities to protect and care for children and vulnerable adults in institutions. We again say sorry to the Stolen Generations and their families for the Catholic Church's complicity in the removal of Aboriginal and Torres Strait Islander children from their Indigenous families. We say sorry to all the survivors of childhood institutional abuse and their families. We commit ourselves to continue to advocate for the humane and just treatment of asylum seekers, refugees and humanitarian entrants.

Because structural sin is non-voluntary and non-individualistic, it can be difficult to grasp our personal and collective responsibility to put things right where possible, and to work for positive change. The sinful personal choices of many people over time can become entrenched in organisational culture, policies, social processes and in institutions. Particular moral responsibility for these situations cannot then be attributed to specific individuals only. All of us who inherit these situations share in the responsibility to address them.

Breaking down structures of sin and building up structures that might better mediate God's grace is part of our mission to transform the world – that it may be on earth as it is in heaven. The witness of those whose physical, mental or spiritual wellbeing has been harmed challenges us all to work for change.

CALLED TO LIVE LIFE TO THE FULL

While the thief comes only to steal, kill and destroy, Jesus has come that we may have life (Jn 10:10). This promise is made in the context of the parable of the Good Shepherd – a story of intimate connection, care and protection (Jn 10:14).⁶³ It is through connection with God, and the quality of relationships into which this calls us, that we will experience the fullness of life in body, mind and spirit, both personally and communally.

In the farewell discourse John reports Jesus' warning to his disciples:

In this world you will have trouble. But take heart! I have overcome the world. (Jn 16:33).

Intimate connection with the heart of God may require us to embrace and find meaning in the vulnerability and suffering that comes with loving. It will draw us to work to eliminate that suffering which cuts people off from God, each other, and the rest of creation – suffering that denies people and communities participation in the fullness of life.

We have identified a range of matters that require reflection and action in our parishes and local communities, and in government policy and service provision. As Bishops, we are confident that the energy, insight and commitment needed are present among members of the Catholic community and all people of goodwill.

Together, we promote the fullness of life for all when we ensure appropriate care for everyone

experiencing mental ill-health:

- when we reject stigmatisation,
- when we work for the transformation of social determinants of mental ill-health,
- when we call for policies and service provision that meet the needs of the poorest, most marginalised and recognise in them the face of Christ Jesus.

As we seek the fullness of life for all under the care of our Australian governments, we recall these words Pope John Paul II spoke to mental health workers 25 years ago:

Whoever suffers from mental illness always bears God's image and likeness in themselves, as does every human being. In addition, they always have 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.⁶⁴

In our parish communities, our institutions and throughout the Church in Australia, we have a duty to break through the stigma of mental illness. As Church, we have the opportunity and responsibility through the Plenary Council 2020 to consider at a deeper level our care for these most vulnerable of our brothers and sisters.

We are called to restore the Body of Christ by making mental health a key priority, acknowledging and including people living with mental ill-health within our communion and the heart of Australian society.

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