Mental health - engagement and response

Pitt Street Uniting Church, 1 October 2017

A Contemporary Reflection by Dr Michael Dudley

Pentecost 17A

Philippians 2: 1-13; Contemporary Reading: *To Full Fruit*, a poem by Andrew King; Matthew 21: 23-32

This reflection can be viewed on You Tube at http://www.pittstreetuniting.org.au/ under "Sunday Reflections" tab

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Today's reflection leads up to World Mental Health Day, on 10 October. Peak body Mental Health Australia speaks about challenging stigma about mental health and help-seeking, and the quest for quality mental health services that enable treatment, care, support and recovery[1]. I invited you to contribute your observations about this topic and had a few responses which I will share throughout, without identification.

I acknowledge the indigenous peoples of this country; all mental health service users, survivors, carers, loved ones, and professionals; our national hostages on Manus Island and Nauru.

Mental health has at least two broad meanings. Firstly, it aspires: the World Health Organisation (WHO) concept of health is '*the highest attainable standard of physical and mental health*' - thus promoting wellbeing, preventing ill-health. Secondly, 'mental health' equals mental health problems, assessments, interventions and services. I am not a mental health consumer or service user – I don't have that particular authority. I work as a mental health clinician, a convenient representative here of thousands of colleagues who have the daily privilege and solemn trust of this work. Mostly we tackle the more severe end of the difficulties that people face: what are often called mental disorders, even severe (or serious) mental illness, the effects of extreme trauma and similar problems.

I apologise to service users who may object to the WHO language as medical, non-recovery focused: the language debate about 'disorders' 'clients' and alternatives is still unresolved. Science, art and ethics all inform our clinical practice, which affords us the honour of hearing so many people's stories – the wide swathe of human experience of pain, along with extraordinary feats of courage, resistance, survival, and of relief and joy. Importantly we also work with carers and loved ones; and with the plight not only of those who come to us but those who are brought in various states of willingness. Sometimes there are profound dilemmas about mental capacity and treatment without informed consent or against one's will.

Finally, there is mental suffering – emotional, existential, spiritual– which is not due to mental disorders or illness, but is associated with anguish and often the need for professional intervention, occurring for example in extreme situations, such as end-of-life.

[1] https://mhaustralia.org/, accessed 1/10/2017

Mental health problems and challenges are ubiquitous. 1 in 5 suffer from any mental disorder at any given time[2] (adults and adolescents). Clinical depression leads causes of disability internationally – 4.4% of the world's population in 2015, while anxiety accounts for 3.6%[3]. Nearly 800,000 people die from suicide each year[4]. Stigma, infringements on legal capacity and freedom from violence and abuse–especially for those with severe or psychotic mental illnesses - remains rife, affecting so many aspects of life. People with mental health problems are far less often likely to be violent, than to be victims of violence. Mental health is fundamental to all physical health problems, but in funding mental health remains the poor cousin[5]. In Australia, NDIS doesn't appear to understand psychosocial health at all and severely ill people are being denied access on a daily basis[6].

Liz Watson reminded me that this reflection needs to be hopeful. This is not hard. In the last 20 years, Australian mental health literacy has improved[7], and people increasingly seek help from mental health services, such as headspace for young people. Psychological services are far more widely available. Many notables e.g. sportspeople, business people, politicians and other courageous Australians brave stigma. Men, especially young men, have been more absent from services than women, and important research on masculinity and suicide has highlighted the problem of male self-reliance and help-avoidance that becomes potentially lethal when men are depressed[8]. Various initiatives have improved help-seeking where this is less likely, in work like the construction industry[9] and rural farming[10].

For depression, anxiety, complex trauma and personality issues, various medical and psychological treatments have proven benefits. New treatments such as TMS and related treatments have shown considerable promise. For psychotic illnesses, there has been a healthy emphasis on exploring the efficacy of psychological treatments in addition to new medical treatments, and to respecting the human rights of those requiring involuntary admission or treatment, including information about rights and reducing the frequency of seclusion and restraint[11]. In suicide prevention, a wide range of effective interventions are recognized for communities and for high risk clinical groups, and several Australian programs in several community settings are implementing these. Indigenous Australians now have a suicide prevention strategy and promising newly trialled interventions to tackle their very high suicide rates[12]. Despite us knowing so much about the social determinants of mental health and relationships with human rights, unfortunately the same cannot be said for asylum-seekers under our present national cruel policies. And unfortunately the safety net is still threadbare for many of our most vulnerable citizens with mental health problems, who are often vainly trying to get a service.

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[2] http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-m-mhaust2-toc~mental-pubs-m-mhaust2-hig~mental-pubs-m-mhaust2-hig-pre

[3] http://apps.who.int/iris/bitstream/10665/254610/1/WHO-MSD-MER-2017.2-eng.pdf?ua=1, accessed 23/9/17

[4] http://www.who.int/mental_health/prevention/suicide/suicideprevent/en/

[5] Dudley M, Silove D, Gale F, Mental health, human rights and their relationship: an introduction. In Dudley M, Silove D, Gale F (eds), Mental Health and Human Rights: vision, praxis and courage. Oxford University Press, Oxford, 2012, p1-49.

[6] https://www.theguardian.com/australia-news/2017/sep/18/ndis-people-with-severe-mental-health-problems-being-denied-access-on-a-daily-basis

[7] http://pmhg.unimelb.edu.au/research_settings/general_community?a=636496

[8] Pirkis J, Spittal MJ, Keogh L, Mousaferiadis T, Currier D. Masculinity and suicidal thinking. Soc Psychiatry Psychiatr Epidemiol. 2017 Mar;52(3):319-327. doi: 10.1007/s00127-016-1324-2. Epub 2016 Dec 26

[9] http://matesinconstruction.org.au/

[10] https://www.crrmh.com.au/content/uploads/Briefing-Paper_FINAL_11052017.pdf

[11] http://www.iimhl.com/files/docs/2017Sydney/Materials/2017_IIMHL_Sydney_SubPlenary_5_Peggy_Brown_MatchPresentation_Reducing_the_Use_of_Seclusion_and_Restraint_in_Australia.pdf

[12] http://www.atsispep.sis.uwa.edu.au/

Importantly reliable support can now be offered to community members, carers and others who need help, through interventions such as Mental Health First Aid[13]: and there has been a profusion of websites and helplines that offer education, treatment and emergency management.

Many groups face increased mental health challenges or suicide risk. While it is impossible to acknowledge all of these, I will briefly consider a few situations where the church has a particular interest.

Acceptance and welcome of LGBTIQ people is a fundamental issue of human rights, individual dignity and equality and fundamental to Pitt St Uniting Church. This stance is also relevant because of the wider church's not infrequent role as a bastion of homophobia. It will be no secret to this congregation that LGBTIQ people internationally have impaired mental health and increased suicidality from discrimination and exclusion, and other structural rights violations. There was one response about the wellbeing of children with gay and lesbian parents. While it is impossible here to discuss the detail, research over some decades shows that such children generally do not differ from children with heterosexual parents in emotional development, likelihood of emotional or behavioural problems, peers and adult relationships, or educational outcomes. The quality of the parent/child relationship and other factors (e.g. family stress or conflict) - not the parent's sexual orientation has an effect on a child's development.[14][15] [16]. Findings about bullying are mixed and may seem to reflect the country's cultural acceptance of LGBTI relationships and parenting[17].

One of the powerful social determinants of mental health is child abuse and neglect, with its close relationship to violence against women[18]. Research over the last 30 years has clearly demonstrated has a strong relationship to later mental health problems[19].

In 6500 private sessions run by the Royal Commission on Institutions and Child Sexual Abuse, 60% of institutions were religious and 52% of perpetrators were clergy. As a Commissioner, indigenous child and adolescent psychiatrist Professor Helen Milroy has heard thousands of searing stories:

The lifetime invisible war of victims, where no-one sees the scars; impacts on physical and mental health, across generations; later life recurrence of traumatic memories, affecting enduring suicide risk and inability to accept care; inability to experience joy and love and peace, because feelings of threat remain; removal of Aboriginal children including wholesale communities moved into institutions; effects on men, unable to reach out for help, unknowing how to parent or to attach to children, and the absence of programs that help them with this; so much potential for intervention where it didn't happen, and so many barriers to disclosure[20].

[13] https://www.mentalhealthfirstaid.org/
[14] Paige, R. U. (2005). Proceedings of the American Psychological Association, Incorporated, for the legislative year 2004. Minutes of the meeting of the Council of Representatives July 28 & 30, 2004, Honolulu, HI. Retrieved November 18, 2004, from the World Wide Web http://www.apa.org/governance/. (To be published in Volume 60, Issue Number 5 of the American Psychologist.)
[15] https://aifs.gov.au/cfca/publications/same-sex-parented-families-australia/childrens-wellbeing-same-sex-parented-families
[16] http://www.aacap.org/aacap/families_and_youth/facts_for_families/fff-guide/Children-with-Lesbian-Gay-Bisexual-and-Transgender-Parents-092.aspx, August 2013, accessed 27/9/17
[17] https://www.theguardian.com/australia-news/2017/oct/23/children-raised-by-same-sex-parents-do-as-well-as-their-peers-study-shows
[18] James M. Domestic violence as a form of child abuse: identification and prevention. NCPC Issues No. 2 Published by the Australian Institute of Family Studies, June 1994. ISSN: 1321-2540 ISBN: 0 642 20336 9
[19] Watts C, Zimmerman C. Violence against women: global scope and magnitude. The Lancet 2002 (6 April); 359 (9313): 1232-1237.
[20] Commissioner Helen Milroy – Royal Commission into institutional responses to child sexual abuse. Keynote address at the Royal Australian and New Zealand College of Psychiatrists conference, Adelaide, 2 May 2017

There have been more than 2500 complaints relating to child sexual abuse in 40 years of the Uniting Church's existence and $17.5 million has been paid to victims. Through the Commission, the UCA has offered an apology to its own and predecessor church victims. The UCA has developed and now revised a National Child Safety Policy Framework that conforms to the Royal Commission's proforma for child safe institutions [21][22]. National and Synod task groups continue to respond to the Royal Commission's work. With Blue Knot Foundation, which aims to empower recovery from childhood trauma, Pitt St Uniting Church hosted an interfaith service last year and South Sydney and Pitt St Uniting Churches are supporting adult survivors at services in a few weeks. Professor Milroy's challenge to her psychiatric audience (and to us) is to change how we act: listening carefully, not shutting people down with too many structured questions (this is likewise important generally in working with suicidal people), being alert for clients' resilience and strengths and the costs of those; being thankful and grateful to them for what they share. There are forms of therapy that may be relevant e.g. trauma-focussed CBT, or DBT, but no short term program is going to suffice. We have to be here for the long haul[23].

Aged care facilities have rightly come under the microscope in recent times, and many aged care facilities are church-based. My 93 year old father-in-law's entry to a Baptist nursing home for high care dementia has led to some comic encounters, such as the woman who pointing at me cried out loudly as I was leaving the unit, '*Nurse, nurse, watch him, he's escaping'*. However there are also really difficult moments – such as Emily (name altered) who said that she had lost her bike and wanted to be taken home, who would repeatedly sing '*Jesus loves me this I know*' and follow this with a question, '*Am I alive or dead*? And a prayer '*I want it to end*'.

How does one respond to Emily? One must imagine the lives of people with dementia as valuable – from our vantage point sustained God's image - rather than expendable or due for termination as some leading experts have said. Assisted suicide or euthanasia for terminal illness or intolerable suffering are already available in some Western societies, and plans for some Australian jurisdictions to introduce assisted suicide are significantly advanced. One further controversial extension in a few countries is to those with mental illness with intolerable and untreatable suffering[24]; and those of advanced years who have grown tired of life and want life to end[25]. Assisted suicide and euthanasia are grounded in the pre-eminence of individual autonomy and in the stated wish to lessen suffering in extremis. There is a major challenge on to examine the values that underpin assisted suicide in general, balancing the claims of individual autonomy with concerns about justice, beneficence and not doing harm to people with disability or who are otherwise vulnerable, and assisted suicide's relationship to society's commitment to suicide prevention. While autonomy implies reasons for living and for dying may differ between different people, a society may insist that it values people's lives while they do not[26]. In the case of older people, that includes determining if that suffering could be more effectively addressed (e.g. by a greater consideration of the needs of older people to stay connected, to ensure more effective detection and treatment of undiagnosed illnesses such as depression[27], and effective palliation where illnesses are untreatable).

[21] http://www.abc.net.au/news/2017-03-10/uniting-church-in-australia-apologises-to-victims/8344496
[22] https://www.theguardian.com/australia-news/2017/mar/10/uniting-church-has-faced-2500-reports-of-child-sexual-abuse-royal-commission-hears
[23] Milroy, op.cit.
[24] Schuklenk U, Van de Vathorst S. Treatment resistant major depressive disorder and assisted dying. J Med Ethics 2015;41:577–583.
[25] Richards N. Old age rational suicide. Sociology Compass. 2017;11:e12456. https:// doi.org/10.1111/soc4.12456
[26] Hale J, quoted by Callaghan S, Ryan C, Kerridge I. Risk of suicide is insufficient warrant for coercive treatment for mental illness. International Journal of Law and Psychiatry 36 (2013) 374–385
[27] Draper B. Elderly men have the highest suicide rate – and ageism stops us doing something about it. The Conversation, September 3, 2015. https://theconversation.com/elderly-men-have-the-highest-suicide-rate-and-ageism-stops-us-from-doing-something-about-it-46923

With rising populations of older people, there is an imperative need for investment and political commitment: to prevent and minimize cognitive impairment and of whole-of-life strategies required for this, stretching back to early childhood education and addressing strong mid-life risk factors[28]. There is also monumental work to be done in acknowledging and supporting the capability, participation, care, creativity and dignity of older persons, especially in their freedom from all types of abuse and enabling distributive justice by making adequate resources available for them, including effective services[29]. A 95 year old Bunnings employee whom Fran and I met yesterday with my father-in-law gave him perfect advice about the pliers and the watersol he was interested in. He was clearly celebrated by his fellow employees (some decades younger) as a real asset. He ascribed his long life and satisfaction to his wife who died 6 weeks ago and unbroken employment. He hadn't been made to retire.

How do we promote mental health and address mental health problems and suffering in our own lives and communities? How might we tackle the social determinants of mental health? Today's lectionary helps us consider the preconditions of mental health. The story of Moses with the elders striking the rock with his staff, bringing water for the desperate people (Ex. 17), invites us to contemplate the literal and symbolic significance of water, our common humanity, basic needs and cry to God when they are not met; the reciprocity between physical and mental wellbeing – often separated in practice, yet in practice inseparable.

What wildernesses do we as church experience; how can we show solidarity; what shared history and community will carry us forward? In the Philippians reading (2:1-13) about Jesus' obedience to death, we find humility and non-attachment to the pursuit of self-fulfillment, status and wealth. What attachments that cause mental suffering, might we empty ourselves of, in order to engage in stewardship and radical charity? Jesus, in overturning the Temple economy in the Roman client state of Israel, healing marginal blind and lame people, and in the parable of the two sons (Matthew 21: 23-32), inverts the order of values that produces poverty and hunger, discrimination and oppression. In the alternate OT reading from Ezekiel 18 and the Babylonian exile, the people recite a proverb that casts them as intergenerational victims. The passage addresses cultural and traditional legacies (scripts, beliefs, practices) that prevent us being truly human and compassionate with ourselves and each other.

We are all invited to work in the vineyard, but why don't we accept the invitation to life, seek or accept help? Sometimes we don't even get to first base: in some cultural settings there is no language around mental health for us to recognize our need. Maybe in the church or the arena of mental health, the word does not challenge oppressive structures[30]. Some people can't work in the vineyard because they have been so injured by their life experiences, they will have obstacles that require sensitivity and discernment.

Someone else has asked if psychiatry sees people of faith as a mere amusement, an aberration of rational thinking, a personal crisis unresolved. How do you maintain a personal faith in the face of probable lack of understanding in your colleagues? Where does spirituality fit with psychiatry? Psychiatrists are taught about cultural diversity and respect, but religious barriers to mental healthcare may operate for clients, for psychiatrists and for clergy/faith-based services – e.g. psychiatrists may be less spiritual or religious than their clients. I speak infrequently about being Christian to clients and colleagues but I don't conceal it either, I give

[28] http://www.smh.com.au/national/health/dementia-shakeup--unsw-and-neura-join-forces-to-form-mega-ageing-and-dementia-reasearch-centre-20170929-gyraq8.html
[29] Peisah C, Brodaty H, O'Neill N. The mental health and rights of mentally ill older people. In Dudley M, Silove D, Gale F (eds). Mental health and human rights: vision, praxis and courage. Oxford: Oxford University Press, 2012.
[30] http://www.edgeofenclosure.org/proper21a.html

talks to colleagues and medical students which address or include materials about religion and spirituality. I almost always make a point of asking my clients about their religious and spiritual beliefs. If they respond in the affirmative I engage them in discussion that follows through on how these beliefs or practices support them or otherwise.

Without minimizing potential negative relationships, a huge body of evidence exists about the positive impacts of religious/spiritual practice on physical and mental health[31]. Evidence exists for many practices that support our quest to remediate anxiety and depression: for example, regular exercise and physical activity; regular meditation, mindfulness and practices like yoga; prayer that sees God as benevolent and engages in giving and receiving help from others (there are forms of cognitive-behavioural therapy that have been adapted for practitioners of different religious traditions). The practice of gratitude is helpful. Fanning my toes as I remember to smile. I give the last word to the person who said that Christ Being with us is more important than the intellectual formulations when the chips are down. Knowing how to hear what God might be saying to us; whether what we are doing is helpful or not, often depends on just having someone there, and being taught and cultivating the skills to be alongside each other.

[31] Koenig H, King D, Carson VB. Handbook of religion and health (second edition), OUP, 2012.