

on the social determinants of health which are most critical in this demographic. Working with prisoners to develop interpersonal and vocational skills can sustain a positive mental state, which then translates into greater productivity. As the *Health of Australia's Prisoners* report recommends, these skills need to be introduced, established and practised throughout the time in prison. This is not always possible. Because of personal circumstance and criminal history, some prisoners are not eligible for these 'correctional programs'. Only a third of prisoners in one survey reported they had participated in correctional programs. Most commonly, these were drug and alcohol programs. Successful integration back into the community is determined by incorporating these learned behaviours when negotiating everyday activity from the time of release. Another hurdle at the time of release is continuity of care, complicated by the number of agencies involved at discharge, which are not connected and which need to be identified and sourced, making access yet another key issue in this area. More cohesive and streamlined services are required around release from prison to ensure that released prisoners are not neglected or overlooked.¹⁸

The life course from a disadvantaged upbringing, delinquency and imprisonment is complex. This article does not dismiss the trauma caused to victims of crime, nor does it condone violence and the negative behaviours of some members in our community. It does however highlight the plight of those who are imprisoned and the health disparities they experienced before, during and after imprisonment. For those trapped in this vicious circle of disadvantage and anti-social behaviour, punishment alone is not sufficient. Something more must be offered. Forensic and correctional research disciplines, including qualitative and quantitative methodologies, are focused on articulating these social and cultural nuances and the sensitivities therein. What is needed above all are targeted health responses and social services appropriate to the needs of this cohort, that do not further vilify their lived experiences, and which can hopefully offer a positive turn towards not reoffending and a better life.

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Many of these issues were addressed in the Social Justice Statement 2011–2012 issued by the Australian Catholic Bishops Conference. Entitled *Building Bridges, Not Walls: Prisons and the Justice System*, this statement explores many issues related to prisons, prisoners and judicial processes. It argues punitive views and a lack of rehabilitative services are contributing to the growing problems Australia is facing in this area. Prison chaplains are often at the front line offering support to all within the prisons. This Social Justice Statement argues that the community response to prisoners should not be contempt

and prejudice, but rather respect and dignity and solidarity.¹⁹ By building bridges across social exclusion, we can ensure that walls don't barricade the most vulnerable within our community.

ENDNOTES

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- ⁵ Emma J Palmer and Asia Begum, "The Relationship between Moral Reasoning, Provicim Attitudes, and Interpersonal Aggression among Imprisoned Young Offenders," *International Journal Offender Therapy Comparative Criminology* 50, no. 4 (August 2006): 446–457.
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- ⁸ Francesca Harris, Gill Hek, and Louise Condon, "Health Needs of Prisoners in England and Wales: The Implications for Prison Healthcare of Gender, Age and Ethnicity," *Health & Social Care in the Community* 15, no. 1 (2007): 56–66; Roger Watson, Anne Stimpson, and Tony Hostick, "Prison Healthcare: A Review of the Literature," *International Journal of Nursing Studies* 41 (2004): 119–128.
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- ¹⁵ Nick de Viggiani, "Unhealthy Prisons: Exploring Structural Determinants of Prison Health," *Sociology of Health & Illness* 29, no. 1 (2007): 115–135 at 115.
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- ¹⁷ Micheal J. Merton, Alex J. Bishop, and Amanda L. Williams, "Prisoner Health and Valuation of Life, Loneliness and Depressed Mood," *American Journal of Health Behavior* 36, no. 2 (2012): 275–288.
- ¹⁸ Wendy Dyer and Paul Biddle, "Prison Health Discharge Planning - Evidence of an Integrated Care Pathway or the End of the Road?," *Social Policy and Society* 12, no. 4 (2013): 521–532.
- ¹⁹ ACBC, *Building Bridges, Not Walls*.

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Dilinie Herbert ✉

When Life is Ending....

In the debate about euthanasia, it is important that we consider all views, including those which might not at first seem attractive to us. Whether we believe in God or not, the views of the Catholic Church make a significant contribution to this debate. The Church does not support the deliberate killing either of oneself or another person. It

also emphasises our moral obligation to respect life and to uphold the dignity of each person.

Despite decades of debate and innumerable books, articles, blogs and every conceivable form of media discussing aspects of euthanasia and assisted suicide (EAS), societies continue to grapple with its moral and ethical implications. Varied definitions of both assisted suicide and euthanasia, together with imprecise and emotive language, have not helped the debate. Ultimately, our views on this matter, as with most ethical decisions, depend on our worldview, values, culture, belief system and much else. Over time, societal attitudes in many Western countries including Australia have changed so that the prime focus has shifted from the community to the individual alone. Also changing is the once strongly held societal belief that all human life is inviolable and worthy of respect. While some may view this as progress, for many others it is destructive and isolating.

When the Catholic Church and other faith-based institutions contribute to the euthanasia debate, secular voices often simply discount their views. They may for example claim that religion is becoming more and more irrelevant, and therefore so should its voice. Even so, the major religions have existed for millennia, which suggests that they must hold some truths to inform us of what it means to be a human being and how we should live in community. This article will explore Catholic teaching about EAS drawing primarily on the *Declaration on Euthanasia* issued by the Congregation for the Doctrine of the Faith (CDF). (This document is also known by a Latin name, *Jura et bona*, which means “rights and values.”) It is hoped that this presentation will inform personal discernment about EAS.

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The Declaration begins by stating: “Human life is the basis of all goods...and...the necessary source...of human activity and of all society.”¹ There is no argument here—without life we do not exist, and we cannot take action.

Life is seen as “a gift of God’s love...to preserve and make fruitful,”² a gift for ourselves and for society. In *Evangelium vitae*, Pope John Paul II added: “Life on earth is not an ‘ultimate’ but a ‘penultimate’ reality; ...entrusted to us, to be preserved with a sense of responsibility and brought to perfection in love and in the gift of ourselves to God and to our brothers and sisters.”³ Catholics believe that the ultimate meaning and purpose of life is union with God achieved fully only in eternal life.⁴ Whilst others may not share this belief, there is in most people a need to belong and a need for union and intimacy, that is, a

need to be loved and to love. Awareness of this deep need is perhaps most acute when life is ending.

For those who believe in the ultimate union with God after death, the dying experience may instead be one of coping with and finding meaning in diminishment and loss. For those who believe in life after death, apprehension of an unknown journey after death can be very daunting. Anxieties about this may be eased however by the loving support, both of those close to them and the medical team who care for them. For those who believe that all is ended with the last breath, the knowledge that they will be loved and can continue to love till they die, may be all that is needed for a good and peace-filled death.

For Catholic Christians, the ethics of gospel love facilitates fulfilment as life is ending by reminding us that our lives are not lived in isolation, and that we are all gifted and essential members of the Body of Christ. Each of us has a responsibility to engender the sense of community and interdependence, and the sense of belonging and being loved for who each one truly is as a human being. Christians believe that each person is made in the image and likeness of God. Each one of us is a vital whole within the greater wholeness of God. Whatever happens to one person affects everyone else. From this perspective, caring for another is not burdensome, either for the carer or the person receiving the care, but rather a living out of the essential truth of our interdependence.

The invitation is therefore to live a full life until natural death occurs, but not necessarily to try to prolong that life with extraordinary or overly burdensome means. The Declaration is very clear that respect for life must always remain. Death should never be intended nor sought.⁵

The CDF supports “the use of medicines” for “alleviating or suppressing pain.” It accepts this intervention even in cases where it may cause “semi-consciousness and reduced lucidity.”⁶ The Declaration also invites us to see the many separations or ‘letting gos’ as preparation for the final separation of death, and, for some Christians, as opportunity for communion with Christ’s suffering.⁷

The CDF identifies a number of considerations to bear in mind when making ethical decisions in end-of-life care. It suggests:

... studying the type of treatment to be used, its degree of *complexity* or *risk*, its *cost* and the possibilities of using it, and comparing these elements with the result that can be expected, *taking into account the state of the sick person and his or her physical and moral resources* [emphasis added].⁸

This highlights an ethical process that considers each individual and their unique circumstances. The Declaration also recognises each individual as the person most qualified to make these end-of-life treatment decisions. Ultimately, “it pertains to the conscience either of the sick person, or of those qualified to speak in the

sick person's name, or of the doctors, to decide, in the light of moral obligations and of the various aspects of the case,"⁹ the right course of action to take. The document continues: "One cannot impose on anyone the obligation to have recourse to a technique... which carries a risk or is burdensome."¹⁰ Withdrawing or withholding burdensome treatment, the Declaration emphasises is not suicide but "an acceptance of the human condition."¹¹ For Christians, end-of-life is about still living life to the full to the end, respecting life as a gift, and when the end comes having the courage to let go in the hope and belief of achieving the ultimate good of union with God.

When a gravely ill person requests aid in dying, the Declaration suggests that this might not imply a true desire for euthanasia: "it is almost always... an anguished plea for help and love. What a sick person needs, besides medical care, is love, the human and supernatural warmth..."¹² of loved ones and the medical team. Given that in recent times the reasons for requesting EAS are usually socio-psycho-spiritual in nature,¹³ there is much truth in this observation.

Healing the whole person is the core purpose of medicine. Even in the final stages of life when cure is not possible, healing can enable a deep peace in one's relationship with self, loved ones and God. To claim that the killing of another should be a medical service as has happened in Quebec,¹⁴ and now in the *Medical Services (Dying with Dignity) Exposure Draft Bill 2014* before the Australian Senate,¹⁵ goes against the very foundation of medicine. To relieve the suffering of another is core to medicine. To comfort is also core. However, to kill another is to cross the line between healing and destroying, and, albeit controversially, outside the scope of medicine.

It is very upsetting to watch loved ones suffer. Apart from possible pain, there is also associated restlessness, lack of control, being trapped in a body that is failing, dependence on others, loss of modesty, the sense of loss of identity, and the inability to do what one could once do (including caring for another and fulfilling one's obligations to society). Fear of the unknown along with associated feelings of powerlessness, loss of control and prolonged dying may also be very confronting, despite assurances from palliative care professionals that pain can usually be controlled or at least made bearable, and psycho-socio-spiritual suffering can be alleviated with the help of a multidisciplinary team. These experts—and many stories—speak of the preciousness of this time as death approaches when relationships can be healed and deepened by simple presence. Many stories are told of people who, despite being incapacitated, lived life to the full till they died, primarily because of loving relationships.¹⁶ In the face of death, with all of our façades stripped away, we are forced to face our true selves. As we do, we often realise that we are respected and unconditionally loved not for what we do, but simply for who we are.

For a small proportion of people, suffering, or the fear of suffering, or whatever else it is, can be experienced as so

unbearable that ending their life prematurely seems the only recourse. Unless we step into their shoes, it would be arrogant to presume to know what they should do. We make what we call conscious choices based on a complex array of intuitive knowing, experiences, knowledge, understandings, values and (for some of us) faith, all of which inform our worldview, and determine our identity, and our meaning and purpose in life. If we are affiliated with a faith tradition, we pay attention to our religious beliefs and their sources—for Catholic Christians, the Bible, tradition, theology, the *sensus fidei* and our prophets. We also call on the experiences, knowledge and expertise of those who have had the privilege of sharing similar end-of-life journeys with others, including palliative care professionals.

If we are considering EAS, we must ask ourselves what the true underlying issue leading us to this point is. We do this by determining all the facts (including our medical diagnosis, treatment options and likely prognosis), listening with the heart to our intuition, and pondering all these things deeply. People of various faiths will also bring all this before and into conversation with God. There can be many questions: If dignity is the issue, then what are the reasons I feel that my dignity is being undermined or not respected? If it is a sense of having completed my life and lacking any reason to go on living, what am I saying about my attitude to my life, and to its meaning and purpose? If suffering is the issue, what are the elements contributing to this? What might be changed? Are there experiences I am now rejecting that I may be able to perhaps grudgingly adapt to or accept? Is there need for greater access to palliative care? Must palliative care expertise improve even more? Is it about attempting to control the uncontrollable, to bring order in the midst of chaos? Might I learn to live with chaos and accept not being in control? Is there anything I must do to come into loving relationship with myself, with my loved ones and (if I believe) with God? What do I need in order to come to the healing place of letting go, and so accept peacefully the approaching end of my life? If honest reflection unearths issues like these, EAS may not be the answer. Perhaps a better solution might be ensuring access to various forms of expertise about the dying process—that is, holistic end-of-life care. Even if palliative care cannot currently relieve all suffering, might the legislating of EAS eventually result in greater threats to older persons, and people with disability, mental illnesses and other vulnerabilities? Despite the so-called legislated safeguards, this is already happening in Belgium.¹⁷

....In the dying process, the role of medicine is not to increase the burden of suffering, nor to pointlessly prolong dying, but also not to end life prematurely....

The contribution that the Catholic Church makes to the euthanasia debate gives us a lot to ponder. The Catholic *Declaration on Euthanasia* speaks of the inviolability of

life, a moral norm upheld for millennia in countless societies. It also reminds us that dying is part of life, and that there is no imperative to prolong dying if treatment will be overly burdensome and cause excessive suffering. The dignity of the individual is interwoven with respect for life. It is upheld and honoured when the person experiences a true sense of belonging, of loving and being loved unconditionally, regardless of their capacity or incapacity.

The purpose of medical technology is to assist the individual in making the most of life, to cure disease where possible, to ease if not eliminate suffering, and to comfort always.¹⁸ In the dying process, the role of medicine is not to increase the burden of suffering, nor to pointlessly prolong dying, but also not to end life prematurely. Further, the role of medicine is to facilitate healing in the individual, by easing their pain and enabling space for the person's 'letting go'. This in turn can facilitate the 'letting come' of graces and deeper awareness of the individual's life, narrative and legacy. (It might also mean handing over to others to write for the individual the final paragraph in their life's narrative when they are no longer physically able to do so.) Thus, medicine can help provide, through the easing of pain and other sufferings, the liminal space of knowing more fully one's primary loving relationships with self, with loved ones, and (if we believe) with God, enabling life to end naturally and peacefully.

ENDNOTES

¹ Congregation for the Doctrine of the Faith, *Declaration on Euthanasia - Jura et bona*, chap. 3, Holy See, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.

² *Ibid.*, chap. 1.

³ John Paul II, *Evangelium Vitae - The Gospel of Life*, n. 2, Holy See, http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html.

⁴ *Declaration on Euthanasia*, chap. 1. See also *Evangelium Vitae*, n. 2: "Man is called to a fullness of life which far exceeds the dimensions of his earthly existence, because it consists in sharing the very life of God."

⁵ *Declaration on Euthanasia*, chap. 2.

⁶ *Ibid.*, chap. 3.

⁷ *Ibid.*, chap. 3. For Christians, the desire for total communion with Christ includes a desire to experience all that Jesus Christ experienced, including his suffering. Thus, St Paul wrote: "I want to know Christ and the power of his resurrection and the sharing of his sufferings by becoming like him in his death, if somehow I may attain the resurrection from the dead." (Phil 3:10–11).

⁸ *Ibid.*, chap. 4.

⁹ *Ibid.*, chap. 4. The moral obligation is to care for the sick "conscientiously and administer the remedies that seem necessary or useful." (Chap. 4) Treatment may be withdrawn if "the results fall short of expectations." (Chap. 4) "The medical profession... ought to neglect no means of making all their skill available to the sick and the dying; but they should also remember how much more necessary it is to provide them with the comfort of boundless kindness and heartfelt charity." (Conclusion).

¹⁰ *Ibid.*, chap. 4.

¹¹ *Ibid.*, chap. 4. The definition of euthanasia in *Evangelium Vitae*, n. 65 is: "Euthanasia in the strict sense is understood to be an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering" [my emphasis]. This improved the definition in the *Declaration on Euthanasia*: "which of itself or by intention causes death..." [my emphasis], chap. 2. For an action to be euthanasia, both criteria must be satisfied: there must be both an intention to cause death and the use of lethal means.

¹² *Ibid.*, chap. 2.

¹³ Christine Monforte-Royo et al., "What Lies behind the Wish to Hasten Death? A Systematic Review and Meta-Ethnography from the Perspective of Patients," *PLoS ONE* 14 May 2012, <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0037117>.

¹⁴ *An Act respecting end-of-life care*, Assemblée Nationale Québec, <http://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-52-40-1.html>.

¹⁵ *Medical Services (Dying with Dignity) Exposure Draft Bill 2014 (Cth)*, Parliament of the Commonwealth of Australia, http://www.aph.gov.au/~media/Committees/Senate/committee/legcon_ctte/dying_with_dignity/Exposure%20draft%20dying%20with%20dignity.pdf.

¹⁶ I know a man with end-stage motor neuron disease, whose only form of communication is through a computer, which he activates by moving his eyes. The love of his new bride gives him reason enough to want to continue to live.

¹⁷ Caroline Ong, "Legalising Euthanasia for Children: Dying with 'Dignity' or Killing the Vulnerable?" *Chisholm Health Ethics Bulletin* 20, no. 1 (Spring 2014): 5–9. See also European Institute of Bioethics, "Euthanasia in Belgium: 10 Years On," *Dossier of the European Institute of Bioethics* (2012); and Raphael Cohen-Almagor, "Euthanasia Policy and Practice in Belgium: Critical Observations and Suggestions for Improvement," *Issues in Law and Medicine* 24, no.3 (2009): 187–218.

¹⁸ A well-known maxim states that the goal of health care is "to cure sometimes, to relieve often, to care always." This quote has been attributed both to Ambrose Pare (physician to King Francois I) and to Edward Livingston Trudeau (the physician who established the Adirondack Cottage Sanitarium at Saranac Lake in New York).

All online documents accessed 19 November 2014.

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Pastoral Care in Aged Mental Health: A Voice at the Table

A Voice at the Table: An Integrated Model for Pastoral Care in Aged Mental Health, written by Rosemary Kelleher with Olga Yastrubetskaya, describes a practical model for integrating pastoral care practitioners into multidisciplinary teams within aged mental health services. While highlighting the importance of spiritual care within healthcare, the book also emphasises the need for pastoral care practitioners to have the essential skills and knowledge vital to being significant members of the multidisciplinary team. This article offers a concise review of a most valuable resource.

Both social worker Rosemary Kelleher and Associate Professor Olga Yastrubetskaya have had many years of experience in aged mental health. This includes many years at the Aged Mental Health service at St Vincent's Hospital, Melbourne. They are both currently Honorary Fellows at the Academic Unit for Psychiatry of Old Age at the University of Melbourne. They co-authored *A Voice at the Table: An Integrated Model for Pastoral Care in Aged Mental Health*¹ in 2011 in collaboration and consultation with other experts in the area of aged mental health. The book aims to highlight the skillset and knowledge required by pastoral care practitioners working in aged mental health settings. The authors propose a practical