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Foreword

Faith-based and community organizations across the United States historically have provided a wide range of social services to persons from all walks of life. They have, for example, helped people who are homeless, conducted supervised recreational activities after school for youth, provided quality day care for young children, and offered support and services to people with mental illnesses. Lives are enhanced by these interactions.

In 2001 President George W. Bush established the Faith-Based and Community Initiative to promote full participation of faith-based and community organizations in the provision of social services. The initiative focuses on elimination of obstacles to organizations' working with the Federal government in funding and operating those services.

In recent years, a number of mental health consumers have informed the Center for Mental Health Services (CMHS), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services, that faith and spirituality are critical in their paths to recovery. Some consumers have asserted that their relationships with faith communities have enhanced their lives; others have claimed that certain attitudes and practices have impeded their recovery.

To explore the roles of faith and community organizations in recovery for people with mental disorders, CMHS sponsored a dialogue between mental health consumers and members of the faith community. Two dozen participants

- ♦ Identified characteristics and issues related to interactions between mental health consumers and members of faith-based and community organizations; and
- ♦ Formulated recommendations for achieving better mutual understanding and creating partnerships to promote recovery among persons with mental illnesses.

Their findings and recommendations are summarized in this monograph.

This dialogue was the fifth in a series of dialogues sponsored by SAMHSA's CMHS. Beginning in 1997, mental health consumers have met with groups of formal mental health providers—psychiatrists, psychologists, social workers, and psychiatric-mental health nurses—to open lines of communication.

SAMHSA welcomes comments and suggestions from consumers, their families, and members of faith-based and community organizations about this monograph and its use. We hope it helps build bridges that support the recovery of persons with mental illnesses.

Acknowledgments

Numerous people contributed to the development of this document (see Participant List). This document was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) under contract number 280-01-8054 with SAMHSA, U.S. Department of Health and Human Services (DHHS). Carole Schauer and Chris Marshall served as the Government Project Officers.

Disclaimer

The views, opinions, and content of this publication are those of the conference participants and do not necessarily reflect the views, opinions, or policies of CMHS, SAMHSA, or DHHS.

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Overview

Evidence is growing of the value of the services and support that faith-based and community organizations offer to people with mental illnesses. These groups often contribute to recovery by promoting hope and by offering solace and comfort in troubled times. However, not all organizations are equally welcoming or knowledgeable about how best to serve people with mental disorders. Further, mental health professionals often overlook the role of faith, spirituality, and religion when working with consumers.

To consider how to develop accepting, healing, supportive partnerships, a group of mental health consumers and representatives of faith-based and community organizations met in Baltimore, Maryland, in October 2002. CMHS sponsored this dialogue to explore ways to build relationships between mental health consumers and members of faith and community organizations to promote recovery from mental illnesses.

The dialogue's participants reflected the diversity of the Judeo-Christian, Muslim, Buddhist, and other traditions. They also represented a wide range of cultural, racial, ethnic, geographical, gender, and age backgrounds. During the course of a two-day, facilitated roundtable discussion, these participants explored many of the interpersonal and systems-level issues that help or hinder recovery. At times, this exploration was painful, yet revealing. The participants also developed a series of recommendations to promote positive relationships between consumers and community and faith-based organizations.

“My responsibility is to help the congregations and seminaries of America to become familiar with physical, sensory, or mental disability. I work with priests, rabbis, ministers, and imams. Congregations want to do a good job, but they don’t know how to do it.”
(Community organizer)

Executive Summary

Faith-based and community organizations have a long tradition of providing essential services to people in need in the United States, including persons with mental illnesses.* To explore productive partnerships and build more effective partnerships between consumers and members of faith-based and community organizations, the Center for Mental Health Services (CMHS), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) within the U.S. Department of Health and Human Services, sponsored a two-day facilitated meeting in October 2002. Two dozen invited consumers and members of diverse faith traditions and community organizations participated.

Participants focused on characteristics of and issues related to interactions between mental health consumers and members of faith-based organizations. They formulated recommendations to achieve better mutual understanding and to create partnerships to promote recovery for persons with mental illnesses.

Some participants spoke about the positive impacts of spirituality and religion on their recovery and coping, while others revealed that some faith communities had displayed a lack of knowledge of how to help them or had turned them away.

Participants identified specific factors within faith and community settings that contribute to or hinder recovery. Factors that promote recovery include a sense of community, rituals and other spiritual practices, an understanding of mental illnesses and psychiatric disabilities, and cultural competence. Factors that hinder recovery include discrimination and stigma, lack of outreach to persons with mental illnesses, an authoritarian perspective and/or lack of openness, and the historical schism between religion and the mental health community. Participants also discussed systems-level issues such as social policy, training for religious leaders and mental health providers, partnerships to address the needs of persons with mental illnesses, the role of the Federal government, and the role of consumers.

*Although a number of terms identify people who use or have used mental health services (e.g., person with a mental disorder, ex-patient, consumer, psychiatric survivor, client, psychiatrically labeled), for consistency throughout this report, the terms “persons with mental illnesses” and “consumers” will be used.

The following highlights dialogue participants' recommendations.

To SAMHSA/Center for Mental Health Services

- ◆ Provide education on mental health services to faith-based and community organizations, including curriculum and program development.
- ◆ Enhance education for health care and social service providers about the roles of faith, spirituality, and religion in recovery.
- ◆ Create ongoing dialogue and foster partnerships between mental health agencies and faith-based communities.
- ◆ Promote best-practices models to assist persons with mental illnesses engaged in the life of faith communities.
- ◆ Provide Federal assistance, monitoring, evaluation, and feedback regarding faith-based and community organizations' services for persons with mental illnesses.
- ◆ Work to foster research related to mental health issues and the faith community.

To Faith-Based Organizations

- ◆ Create a welcoming, supportive environment for mental health consumers.
- ◆ Introduce instruction on mental health and mental illnesses as required topics in seminary education.
- ◆ Create partnerships between consumers and faith-based organizations for education.
- ◆ Address issues of discrimination and stigma, including dealing openly, positively, and compassionately with clergy with their own mental health issues.
- ◆ Educate mental health providers about the role of chaplains in psychiatric hospitals as part of the treatment team.

To Consumers and Consumer Advocates

- ◆ Develop a compendium of best practices and lessons learned about engaging faith communities to create welcoming environments for people with mental health issues.
- ◆ Volunteer to share faith-based stories with congregations and consumer conferences to put a face on recovery and the role that spirituality plays in recovery; establish speakers bureaus.
- ◆ Organize dialogues between faith communities and mental health consumers.
- ◆ Mobilize consumer groups to prepare reference manuals on mental health and other social support resources in their communities for the benefit of clergy, schools, and other groups.

Dialogue Themes and Findings

As the dialogue began, participants shared in-depth, personal experiences in consumer-faith interactions that have promoted or hindered recovery from mental illnesses. By telling personal stories, participants understood better the context from which they each spoke, and they learned that they had shared many of the same types of experiences. The stories helped increase empathy and reduce perceived differences among the participants. These histories lay the foundation for further discussion dialogues to build partnerships.

Some participants spoke about the positive impact of spirituality and either personal or organized religion on their recovery and coping . . .

“I believe that a relationship with God and spirituality are the most important supports to help us recover.” (Consumer)

“The one thing that kept me from going off the deep end after three suicide attempts was that God had other plans for me.” (Consumer)

“My spirituality is internal. After having been locked up in seclusion for 45 days, I discovered I had found spirit.” (Consumer)

Others revealed the pain they suffered due to some faith communities’ lack of knowledge of how to help them . . .

“Mental illness is a ‘no casserole’ disease. When you have other illnesses, congregations reach out— not always with mental illness.” (Family member)

Some told stories about having been turned away by faith communities and their leaders . . .

“I have worked with religious people for eons, and I have been turned away many times. Once in a while, I’d come across a religious group that would tolerate me for a tad, but not for long.” (Consumer)

Participants who work as advocates for persons with mental health problems described how both positive and negative experiences affected their work . . .

“I finished seminary, but I realized I would not flourish where people would be suspicious of my abilities and performance. Also I was recognizing that people were not speaking up about mental illness, and people had no one to advocate for them. I decided to pursue advocacy rather than ordination.” (Consumer)

Leaders of faith communities discussed encountering and/or fashioning welcoming environments for persons with mental illnesses . . .

“Some congregations have hired therapists for families and members who have mental illnesses. The services provided are free to those families.”
(Consumer)

“It took me twenty years until I found a church that wanted to do a ministry to people with severe mental illnesses. We wanted consumers integrated into all parts of the church. The vision just exploded. We have maybe a hundred consumers in all.” (Clergy/consumer)

Some participants described their work with community-based support programs that include a focus on spirituality. . .

“We made major changes in the local mental health system. We invited ministers, consumers, and staff. We wanted to look at spirituality in new ways to be helpful to people we serve. We started training mental health staff and religious professionals to run therapy groups as part of the services.”
(Mental health professional)

“I am not a mental health consumer, but I have interacted with many consumers. It is my charge and calling to enable our faith’s resources to reach out into the community in partnership with government. But the armies of compassion are not engaged. Our churches tend to build walls.”
(Faith community worker)

Factors That Promote Recovery

Participants identified factors that contribute to recovery within faith and community organization settings:

A sense of community

- ◆ Faith communities can offer a safe, comfortable, nonjudgmental environment to mental health consumers.
- ◆ Personal outreach, the development of a social network, and the community’s gifts of “being present,” of listening, and of friendship contribute to a validating environment. An organization’s spirit of hospitality, expressed by both clergy and congregants, can serve as a welcoming beacon.
- ◆ Persons with mental illnesses have opportunities for self-disclosure—to tell their personal stories.
- ◆ People have opportunities to forge connections in a spirit of trust and acceptance.

- ◆ Consumers' participation in and contributions to the faith community are valued.
- ◆ A consumer can begin a relationship with a faith community simply by telling his or her story to a member of the clergy or a lay leader and explaining how faith has been important for coping with a mental illness personally or in the family.

“Consumers across the country consider their top needs to be housing, jobs, and social supports. Faith and community organizations play such a crucial role in these areas.” (Consumer)

Rituals and other spiritual practices. Faith-based rituals and other spiritual practices can foster recovery among persons with mental illnesses. Rituals and other practices can include

- Prayer (personal and congregational, formal and informal)
- Personal testimony
- Meditation

The forms may differ, but spiritual practices are an important aspect and value of a faith community's connection with mental health consumers. Faith communities can help people achieve solace and foster a greater sense of belonging.

“Talking about mental illness from the pulpit is healing and opens doors.” (Consumer)

Understanding mental illnesses and psychiatric disabilities.

Faith communities that understand mental illnesses and psychiatric disabilities are better able to meet the needs of mental health consumers. The following concepts are important for faith communities both to understand and to act on:

- People can recover from mental illnesses.
- Each consumer has unique needs that require individual supports, rather than “cookie-cutter” approaches.
- Discrimination and stigma impede recovery. Faith communities that help overcome fears, stigma, and discrimination regarding mental illness are better able to serve persons with mental illnesses.
- “Connectedness” to family, faith, peers, the faith community—or anyone who listens and supports during a time of need—is important to persons with mental illnesses. Empathy and listening help build relationships.

A holistic mind/body/spirit approach that acknowledges a person's strengths (as well as weaknesses) places mental illness and psychiatric disability in the context of the whole person.

- The cyclical nature of some mental illnesses highlights the need for faith communities' commitment to ongoing involvement with (and outreach to) consumers and their families.
- Awareness that co-occurring disorders, such as substance use or a physical disability, may accompany and inhibit recovery from mental illnesses is helpful.

"Sharing my story has been one of the greatest ways to relieve stigma. A few months ago, I organized a walk across Wisconsin for awareness."
(Clergy/consumer)

Cultural competence

- ◆ A faith community's awareness of mental health consumers' backgrounds—including language and cultural understanding of mental health—in accommodating their needs is important to recovery.
- ◆ Using "people-first" language—saying "a person with mental health issues" or "a person with a mental illness," rather than "a mentally ill person"—is an important practice in a welcoming community.
- ◆ It is important to understand that traditional healing practices, in addition to or instead of contemporary mental health practices, may be important to some persons with mental illnesses.

"Many small, ethnic minority churches impacted more on me than a community support program, because of the cultural affinity."
(Faith community organizer)

Other factors

- ◆ Mutual aid: Individuals help themselves when they support others.
- ◆ Tradition: A sense of historical connection related to faith can be healing.

Factors That Hinder Recovery

Participants identified a number of factors, related to consumers, faith communities, and the broader community, that can impede recovery:

Discrimination and stigma. The existence of discrimination and stigma within faith communities contributes to the burden of silence and secrecy consumers carry about their mental illnesses. They may feel shame about their illnesses and fear being judged negatively by members of the faith community because of their illnesses. The perception by members of the faith community that mental health consumers are somehow “different” may further heighten stigma and discrimination.

“I attempted to talk with my priest about my bipolar disorder, but I got the notion that I wasn’t to talk about this.” (Consumer)

Lack of outreach to persons with mental illnesses

- ◆ Welcoming people with mental illnesses is not a priority for some faith communities.
- ◆ Some communities lack knowledge about outreach strategies and practices.

Authoritarian perspective and/or lack of openness in some faith-based organizations. The hierarchies of some faith communities discriminate against and stigmatize clergy with mental illnesses. Many clergy who suffer from mental health problems fear seeking care because their positions in their pulpits may be endangered.

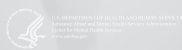
“As pastor, I kept my mental illness secret from my congregation for two years. Carrying the burden of silence is most difficult. They tried to put me on involuntary disability, to kick me out of the ministry.”
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Historical schism between religion and the mental health community.

For more than a century, organized religion and the health field have taken divergent—and sometimes antagonistic—paths in their approaches to mental health. Consequently, many religious leaders lack an understanding of mental health issues and the possibility for recovery, while many health and mental health providers lack an appreciation for the significant role that religion, spirituality, and the faith community may play in healing.

Spiritual crises or emergencies not often validated. For many persons experiencing psychosis, there is a fine line between spirituality and madness. These “spiritual crises” or “emergencies” often are not validated by mental health professionals.

“How a person comes to accept and understand these experiences (spiritual crises) may be a key to their recovery, including believing and calling up a higher power for help.” (Consumer)



System-Level Issues That Impact Recovery

In discussion of contextual issues, dialogue participants identified many factors that affect relationships between mental health consumers and faith-based organizations. These factors center around institutions that train religious and mental health providers, social policy, partnerships among community organizations that address the needs of persons with mental illnesses, the role of the Federal government in helping faith- and community-based organizations provide social services, and the role of consumers, among others.

Education and training

- ◆ Seminary training typically does not address the relationship between issues of spirituality and mental health.
- ◆ Training programs for mental health professionals lack instruction on the values and role of faith, spirituality, and religion in healing mental illnesses, and on how to integrate traditional healing practices.
- ◆ Chaplains in State hospitals—and clergy in general—typically are not considered integral members of the healing process or of the mental health team.

“Many practitioners don’t understand the role of spirituality.” (Mental health provider)

Faith-based organizations and social policy

- ◆ Faith-based organizations can reach beyond the charity model and implement a model that focuses on recovery, with and by persons with mental illnesses.
- ◆ Faith-based organizations can serve as a bridge when they focus on mental health issues, including discrimination and stigma in housing, insurance parity, seclusion and restraint, the criminal justice system, and addictions.
- ◆ Faith communities that wish to influence social policy and bring about social justice must allocate resources to undertake this work.

Issues of church and state. Some faith communities and government agencies avoid working with each other to provide social services because of misperceptions about the legal relationship between church and state. Education is needed to clarify the appropriate relationship.

“The faith community needs to be helpful in trying to overcome the resistance of the public health community.” (Consumer)

Consumer participation

- ◆ Consumer representation on faith-based organizations’ advisory groups and governing boards contributes to relevance of the organizations’ programs.
- ◆ Consumers can serve in faith-based organizations as change agents, role models, and contributing members.
- ◆ Hierarchies in faith-based organizations and/or religious leaders may create barriers to participation for members, potential members, and clergy with mental health issues.
- ◆ “Nothing about us without us.” Consumer empowerment is fostered by the involvement of consumers in all aspects of their connection with their faith community. Education about and access to information or services that are relevant and culturally competent empower consumers to make informed decisions.

Linkages between faith and community organizations

- ◆ Clergy need to know when and where to refer a person with mental health issues, and also to know how to support that person in the congregation.
- ◆ Mental health providers need tools to help them incorporate spirituality into their repertoires of healing techniques.

Faith-based initiative policy

- ◆ Officials of public mental health programs may see faith-based approaches as an opportunity to cut costs and to undermine or supplant the work of experienced mental health professionals. Emphasis on delivery of high-quality mental health services is imperative.
- ◆ It is important to provide technical assistance systematically to small faith-based and community organizations that serve people with mental illnesses to enable those organizations to compete successfully for Federal resources.

◆ Funds should be directed where the need is greatest. Technical assistance can enhance faith-based organizations' capability to use funds responsibly and effectively, and to integrate their work with the health care delivery system.

Research to develop the evidence base. Research should be directed toward the contributions of chaplains and faith-based organizations in the treatment and recovery of individuals with mental illnesses, and toward the factors that impede outreach to consumers.

Community organizing

- ◆ To implement effective links between faith-based and community organizations and mental health providers and consumers, all relevant stakeholders must join at the planning table in a collaborative framework.
- ◆ Collaborations and partnerships need to set short- and long-term goals that are incrementally achievable and measurable.

*"I help to build multi-ethnic, interfaith coalitions around quality of life. I'm a community organizer with a spiritual imperative."
(Clergy/community organizer)*

Dialogue Themes and Findings

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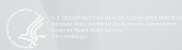
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System-Level Issues That Impact Recovery

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Education and training

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- ◆ Chaplains in State hospitals—and clergy in general—typically are not considered integral members of the healing process or of the mental health team.

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- ◆ Faith communities that wish to influence social policy and bring about social justice must allocate resources to undertake this work.

Issues of church and state. Some faith communities and government agencies avoid working with each other to provide social services because of misperceptions about the legal relationship between church and state. Education is needed to clarify the appropriate relationship.

“The faith community needs to be helpful in trying to overcome the resistance of the public health community.” (Consumer)

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- ◆ Consumer representation on faith-based organizations’ advisory groups and governing boards contributes to relevance of the organizations’ programs.
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- ◆ “Nothing about us without us.” Consumer empowerment is fostered by the involvement of consumers in all aspects of their connection with their faith community. Education about and access to information or services that are relevant and culturally competent empower consumers to make informed decisions.

Linkages between faith and community organizations

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- ◆ Mental health providers need tools to help them incorporate spirituality into their repertoires of healing techniques.

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- ◆ Officials of public mental health programs may see faith-based approaches as an opportunity to cut costs and to undermine or supplant the work of experienced mental health professionals. Emphasis on delivery of high-quality mental health services is imperative.
- ◆ It is important to provide technical assistance systematically to small faith-based and community organizations that serve people with mental illnesses to enable those organizations to compete successfully for Federal resources.

◆ Funds should be directed where the need is greatest. Technical assistance can enhance faith-based organizations' capability to use funds responsibly and effectively, and to integrate their work with the health care delivery system.

Research to develop the evidence base. Research should be directed toward the contributions of chaplains and faith-based organizations in the treatment and recovery of individuals with mental illnesses, and toward the factors that impede outreach to consumers.

Community organizing

- ◆ To implement effective links between faith-based and community organizations and mental health providers and consumers, all relevant stakeholders must join at the planning table in a collaborative framework.
- ◆ Collaborations and partnerships need to set short- and long-term goals that are incrementally achievable and measurable.

*"I help to build multi-ethnic, interfaith coalitions around quality of life. I'm a community organizer with a spiritual imperative."
(Clergy/community organizer)*

Dialogue Themes and Findings

As the dialogue began, participants shared in-depth, personal experiences in consumer-faith interactions that have promoted or hindered recovery from mental illnesses. By telling personal stories, participants understood better the context from which they each spoke, and they learned that they had shared many of the same types of experiences. The stories helped increase empathy and reduce perceived differences among the participants. These histories lay the foundation for further discussion dialogues to build partnerships.

Some participants spoke about the positive impact of spirituality and either personal or organized religion on their recovery and coping . . .

“I believe that a relationship with God and spirituality are the most important supports to help us recover.” (Consumer)

“The one thing that kept me from going off the deep end after three suicide attempts was that God had other plans for me.” (Consumer)

“My spirituality is internal. After having been locked up in seclusion for 45 days, I discovered I had found spirit.” (Consumer)

Others revealed the pain they suffered due to some faith communities’ lack of knowledge of how to help them . . .

“Mental illness is a ‘no casserole’ disease. When you have other illnesses, congregations reach out— not always with mental illness.” (Family member)

Some told stories about having been turned away by faith communities and their leaders . . .

“I have worked with religious people for eons, and I have been turned away many times. Once in a while, I’d come across a religious group that would tolerate me for a tad, but not for long.” (Consumer)

Participants who work as advocates for persons with mental health problems described how both positive and negative experiences affected their work . . .

“I finished seminary, but I realized I would not flourish where people would be suspicious of my abilities and performance. Also I was recognizing that people were not speaking up about mental illness, and people had no one to advocate for them. I decided to pursue advocacy rather than ordination.” (Consumer)

Leaders of faith communities discussed encountering and/or fashioning welcoming environments for persons with mental illnesses . . .

“Some congregations have hired therapists for families and members who have mental illnesses. The services provided are free to those families.”
(Consumer)

“It took me twenty years until I found a church that wanted to do a ministry to people with severe mental illnesses. We wanted consumers integrated into all parts of the church. The vision just exploded. We have maybe a hundred consumers in all.” (Clergy/consumer)

Some participants described their work with community-based support programs that include a focus on spirituality. . .

“We made major changes in the local mental health system. We invited ministers, consumers, and staff. We wanted to look at spirituality in new ways to be helpful to people we serve. We started training mental health staff and religious professionals to run therapy groups as part of the services.”
(Mental health professional)

“I am not a mental health consumer, but I have interacted with many consumers. It is my charge and calling to enable our faith’s resources to reach out into the community in partnership with government. But the armies of compassion are not engaged. Our churches tend to build walls.”
(Faith community worker)

Factors That Promote Recovery

Participants identified factors that contribute to recovery within faith and community organization settings:

A sense of community

- ◆ Faith communities can offer a safe, comfortable, nonjudgmental environment to mental health consumers.
- ◆ Personal outreach, the development of a social network, and the community’s gifts of “being present,” of listening, and of friendship contribute to a validating environment. An organization’s spirit of hospitality, expressed by both clergy and congregants, can serve as a welcoming beacon.
- ◆ Persons with mental illnesses have opportunities for self-disclosure—to tell their personal stories.
- ◆ People have opportunities to forge connections in a spirit of trust and acceptance.

- ◆ Consumers' participation in and contributions to the faith community are valued.
- ◆ A consumer can begin a relationship with a faith community simply by telling his or her story to a member of the clergy or a lay leader and explaining how faith has been important for coping with a mental illness personally or in the family.

“Consumers across the country consider their top needs to be housing, jobs, and social supports. Faith and community organizations play such a crucial role in these areas.” (Consumer)

Rituals and other spiritual practices. Faith-based rituals and other spiritual practices can foster recovery among persons with mental illnesses. Rituals and other practices can include

- Prayer (personal and congregational, formal and informal)
- Personal testimony
- Meditation

The forms may differ, but spiritual practices are an important aspect and value of a faith community's connection with mental health consumers. Faith communities can help people achieve solace and foster a greater sense of belonging.

“Talking about mental illness from the pulpit is healing and opens doors.” (Consumer)

Understanding mental illnesses and psychiatric disabilities.

Faith communities that understand mental illnesses and psychiatric disabilities are better able to meet the needs of mental health consumers. The following concepts are important for faith communities both to understand and to act on:

- People can recover from mental illnesses.
- Each consumer has unique needs that require individual supports, rather than “cookie-cutter” approaches.
- Discrimination and stigma impede recovery. Faith communities that help overcome fears, stigma, and discrimination regarding mental illness are better able to serve persons with mental illnesses.
- “Connectedness” to family, faith, peers, the faith community—or anyone who listens and supports during a time of need—is important to persons with mental illnesses. Empathy and listening help build relationships.

A holistic mind/body/spirit approach that acknowledges a person's strengths (as well as weaknesses) places mental illness and psychiatric disability in the context of the whole person.

- The cyclical nature of some mental illnesses highlights the need for faith communities' commitment to ongoing involvement with (and outreach to) consumers and their families.
- Awareness that co-occurring disorders, such as substance use or a physical disability, may accompany and inhibit recovery from mental illnesses is helpful.

"Sharing my story has been one of the greatest ways to relieve stigma. A few months ago, I organized a walk across Wisconsin for awareness."
(Clergy/consumer)

Cultural competence

- ◆ A faith community's awareness of mental health consumers' backgrounds—including language and cultural understanding of mental health—in accommodating their needs is important to recovery.
- ◆ Using "people-first" language—saying "a person with mental health issues" or "a person with a mental illness," rather than "a mentally ill person"—is an important practice in a welcoming community.
- ◆ It is important to understand that traditional healing practices, in addition to or instead of contemporary mental health practices, may be important to some persons with mental illnesses.

"Many small, ethnic minority churches impacted more on me than a community support program, because of the cultural affinity."
(Faith community organizer)

Other factors

- ◆ Mutual aid: Individuals help themselves when they support others.
- ◆ Tradition: A sense of historical connection related to faith can be healing.

Factors That Hinder Recovery

Participants identified a number of factors, related to consumers, faith communities, and the broader community, that can impede recovery:

Discrimination and stigma. The existence of discrimination and stigma within faith communities contributes to the burden of silence and secrecy consumers carry about their mental illnesses. They may feel shame about their illnesses and fear being judged negatively by members of the faith community because of their illnesses. The perception by members of the faith community that mental health consumers are somehow “different” may further heighten stigma and discrimination.

“I attempted to talk with my priest about my bipolar disorder, but I got the notion that I wasn’t to talk about this.” (Consumer)

Lack of outreach to persons with mental illnesses

- ◆ Welcoming people with mental illnesses is not a priority for some faith communities.
- ◆ Some communities lack knowledge about outreach strategies and practices.

Authoritarian perspective and/or lack of openness in some faith-based organizations. The hierarchies of some faith communities discriminate against and stigmatize clergy with mental illnesses. Many clergy who suffer from mental health problems fear seeking care because their positions in their pulpits may be endangered.

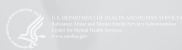
*“As pastor, I kept my mental illness secret from my congregation for two years. Carrying the burden of silence is most difficult. They tried to put me on involuntary disability, to kick me out of the ministry.”
(Clergy/consumer)*

Historical schism between religion and the mental health community.

For more than a century, organized religion and the health field have taken divergent—and sometimes antagonistic—paths in their approaches to mental health. Consequently, many religious leaders lack an understanding of mental health issues and the possibility for recovery, while many health and mental health providers lack an appreciation for the significant role that religion, spirituality, and the faith community may play in healing.

Spiritual crises or emergencies not often validated. For many persons experiencing psychosis, there is a fine line between spirituality and madness. These “spiritual crises” or “emergencies” often are not validated by mental health professionals.

“How a person comes to accept and understand these experiences (spiritual crises) may be a key to their recovery, including believing and calling up a higher power for help.” (Consumer)



System-Level Issues That Impact Recovery

In discussion of contextual issues, dialogue participants identified many factors that affect relationships between mental health consumers and faith-based organizations. These factors center around institutions that train religious and mental health providers, social policy, partnerships among community organizations that address the needs of persons with mental illnesses, the role of the Federal government in helping faith- and community-based organizations provide social services, and the role of consumers, among others.

Education and training

- ◆ Seminary training typically does not address the relationship between issues of spirituality and mental health.
- ◆ Training programs for mental health professionals lack instruction on the values and role of faith, spirituality, and religion in healing mental illnesses, and on how to integrate traditional healing practices.
- ◆ Chaplains in State hospitals—and clergy in general—typically are not considered integral members of the healing process or of the mental health team.

“Many practitioners don’t understand the role of spirituality.” (Mental health provider)

Faith-based organizations and social policy

- ◆ Faith-based organizations can reach beyond the charity model and implement a model that focuses on recovery, with and by persons with mental illnesses.
- ◆ Faith-based organizations can serve as a bridge when they focus on mental health issues, including discrimination and stigma in housing, insurance parity, seclusion and restraint, the criminal justice system, and addictions.
- ◆ Faith communities that wish to influence social policy and bring about social justice must allocate resources to undertake this work.

Issues of church and state. Some faith communities and government agencies avoid working with each other to provide social services because of misperceptions about the legal relationship between church and state. Education is needed to clarify the appropriate relationship.

“The faith community needs to be helpful in trying to overcome the resistance of the public health community.” (Consumer)

Consumer participation

- ◆ Consumer representation on faith-based organizations’ advisory groups and governing boards contributes to relevance of the organizations’ programs.
- ◆ Consumers can serve in faith-based organizations as change agents, role models, and contributing members.
- ◆ Hierarchies in faith-based organizations and/or religious leaders may create barriers to participation for members, potential members, and clergy with mental health issues.
- ◆ “Nothing about us without us.” Consumer empowerment is fostered by the involvement of consumers in all aspects of their connection with their faith community. Education about and access to information or services that are relevant and culturally competent empower consumers to make informed decisions.

Linkages between faith and community organizations

- ◆ Clergy need to know when and where to refer a person with mental health issues, and also to know how to support that person in the congregation.
- ◆ Mental health providers need tools to help them incorporate spirituality into their repertoires of healing techniques.

Faith-based initiative policy

- ◆ Officials of public mental health programs may see faith-based approaches as an opportunity to cut costs and to undermine or supplant the work of experienced mental health professionals. Emphasis on delivery of high-quality mental health services is imperative.
- ◆ It is important to provide technical assistance systematically to small faith-based and community organizations that serve people with mental illnesses to enable those organizations to compete successfully for Federal resources.

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- ◆ To implement effective links between faith-based and community organizations and mental health providers and consumers, all relevant stakeholders must join at the planning table in a collaborative framework.
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*"I help to build multi-ethnic, interfaith coalitions around quality of life. I'm a community organizer with a spiritual imperative."
(Clergy/community organizer)*

Recommendations for Improving Relationships Between Consumers and Faith-Based and Community Organizations

Drawing on the factors identified, participants developed a set of recommendations for improving relationships between consumers and faith-based and community organizations. These recommendations reflect the combined thinking of the participants, but not a consensus. The group's recommendations are presented below, organized by broad target audience and then by major theme. The primary audiences for these recommendations are SAMHSA and other HHS agencies, faith-based organizations, consumers and consumer advocates, and other interested individuals and organizations. Some recommendations appear in more than one category.

Recommendations to SAMHSA/CMHS

1. Provide education to faith-based and community organizations.
 - a. Develop educational curricula and programs to assist faith-based and community organizations in learning about mental illnesses and co-occurring disorders. Suggested topics include
 - i. What are mental illnesses and psychiatric disabilities?
 - ii. Reducing or eliminating discrimination and stigma
 - iii. Recovery
 - iv. Importance of faith and spirituality in mental health recovery; need for a “healing place”
 - v. Creating a supportive, welcoming environment
 - vi. Techniques for outreach (including assessment)
 - vii. Possibility of relapse and its implications for long-term relationships between consumers and the faith community
 - viii. Cultural competence
 - ix. Grant-writing skills



- x. Federal, State, and local mental health agencies and programs
 - xi. How to help consumers navigate the mental health system; how and when to make referrals to appropriate supports
 - b. Facilitate ways for faith-based organizations to consider their responsibility to assist people with mental health issues in meeting their basic needs, such as housing, social service and vocational supports, and other resources. Encourage clergy and lay leaders of faith-based organizations, as part of their mission, to address the needs of mental health consumers. Address the needs of clergy with mental illnesses facing discrimination and stigma.
2. Enhance education for health care and social service providers.
 - a. Develop an educational program to assist health care, mental health care, and social services providers in understanding the importance of faith and spirituality in recovery. Include explicit guidelines and training on spirituality in recovery.
 - b. Include information for and about faith-based organizations in all SAMHSA materials (for example, add a fact sheet to the CMHS Anti-Stigma Kit).
 - c. Work with schools of medicine, psychology, nursing, and social work to add to their curricula a focus on a holistic approach to wellness that integrates physical and mental health and the role of spirituality.
 - d. Sponsor development of (1) instruments that can assess a person's spiritual history, interests, and mental health needs; (2) techniques to integrate that information into treatment planning; and (3) competencies for mental health providers to address their clients' spiritual needs.
3. Create ongoing dialogue and foster partnerships between mental health agencies and faith-based communities.
 - a. Initiate communication among SAMHSA and faith-based organizations, including clergy and lay representatives of faith-based organizations serving on national advisory councils and consumer subcommittees.
 - b. Encourage collaboration and interaction among the faith community, consumers, family members, advocates, providers, community organizations, and government agencies. Provide incentives to bring communities together to implement recommendations.

- c. Sponsor regional dialogues among health and mental health professionals, clergy and lay faith community leaders, and consumers. Develop, publish, and disseminate guidance for State and local entities to host similar dialogues.
 - d. Develop a video on how to forge partnerships between consumers and faith-based and community organizations.
 - e. Encourage the development of links between public health agencies and faith-based organizations. For example, some public health care agencies turn to local congregations to contribute funds to pay for medications for people who cannot afford them.
- 4. Encourage consumer involvement.
 - a. Encourage consumer participation at all levels of planning, research, education, program development, and policy.
 - b. Assist consumer groups in compiling reference manuals for the benefit of clergy, schools, and other groups regarding mental health and social support resources in their communities.
- 5. Promote best-practices models.
 - a. Publish success stories of persons with mental illnesses engaged in the life of faith communities.
 - b. Compile a list of best-practices models and resources and develop strategies to share lessons learned.
 - c. Create a Web site and listserv to exchange information on successful faith-based and consumer initiatives.
- 6. Provide Federal assistance, monitoring, evaluation, and feedback.
 - a. Recommend that the U.S. Department of Health and Human Services establish a national advisory council to enable faith-based and community organizations to inform policy development.
 - b. Outline a strategy to determine incremental, achievable, and measurable goals that can be implemented for system change related to the inclusion of faith and spirituality in mental health service delivery.
 - c. Monitor Federal funding of the faith-based and community initiative to ensure that organizations that provide mental health services have the opportunity to apply for funding.
 - d. Monitor faith-based services to ensure that the quality of mental health services and professionals are maintained and promoted.

- e. Establish dissemination and communication strategies and feedback mechanisms for activities related to the faith-based and community initiative.

7. Foster research.

- a. Conduct research on impediments to integration of persons with mental health issues into the faith community. Investigate factors that inhibit and promote interaction.
- b. Conduct research on the role of chaplains in the recovery process, perhaps in conjunction with the Department of Veterans Affairs.
- c. Develop criteria to evaluate the effectiveness of faith-based mental health programs.
- d. Include grants for faith-based organizations in small communities.

Recommendations to Faith-Based Organizations

1. Create a welcoming, supportive environment for mental health consumers.
 - a. Learn how consumers can request help from congregations and establish openness to these contacts.
 - b. Educate ushers, greeters, and other lay persons to welcome people with mental illnesses.
 - c. Address the unique needs of individuals with mental illnesses.
 - d. Take a strengths-based approach that includes the expectation for recovery.
2. Introduce instruction on mental health and mental illnesses as required topics in seminary education.
3. Use CMHS's "Participatory Dialogue" guide to organize dialogues in local communities.
4. Create partnerships between consumers and faith-based organizations for education.
 - a. Enable faith communities to interact directly with consumers.
 - b. Teach faith-based organizations to reach out to consumers with mental health issues, including determining who they are, how to contact them, and identifying their needs.
 - c. Host forums on issues related to mental health and mental illness.
 - d. Invite consumers to share their stories to bring a face to recovery, to explain the role that spirituality played to help

them recover, and to help clergy and chaplains understand how to support consumers who want to look at their experiences in a spiritual context, as well as, or instead of, an illness context.

- e. Compile inspirational writings to stimulate communication about consumers' journeys.
5. Develop curricula to address and demythologize mental illness for adults and children suitable for use and adaptation by faith-based organizations.
6. Develop a fact sheet on faith and spirituality in mental health.
7. Increase awareness and skills related to cultural competence.
 - a. Use nondiscriminatory, nonstigmatizing language regarding mental health issues.
 - b. Accommodate the language and other needs of individuals from diverse cultures.
8. Address issues of discrimination and stigma.
 - a. Avoid decision-making based on stereotypes, stigma, and imagined worst-case scenarios regarding persons with mental illnesses.
 - b. Mitigate discrimination and stigma in the thinking of both members and clergy.
 - c. Deal openly, positively, and compassionately with clergy who have their own mental health issues.
9. Educate mental health providers about the role of chaplains in psychiatric hospitals as part of the treatment team.
10. Provide support for the grieving process related to having a disability, which includes mental illnesses.
11. Consider the social ramifications of mental illnesses and work to improve conditions such as housing and employment.
12. Include consumers on committees and governing boards of faith-based organizations.
13. Provide transportation resources to enable consumers to participate in the activities of faith communities.

Recommendations to Consumers and Consumer Advocates

1. Develop a compendium of best practices and lessons learned about engaging faith communities to create supportive, welcoming environments for people with mental health issues.
2. Develop guidelines for faith-based organizations on factors involved in creating a supportive, welcoming environment.

3. Educate consumers and consumer groups on techniques to engage with faith-based organizations and to create change.
4. Contribute to the development of curricula about the needs of persons with mental health issues and faith-based programs.
5. Volunteer to share faith-based stories with congregations in order to put a face on recovery and the role that spirituality plays in recovery; establish local speakers bureaus of consumers willing to share their stories.
6. Present at consumer conferences on the role of spirituality in recovery and how to create positive change in faith-based organizations so that they welcome people with mental health issues.
7. Organize dialogues between faith-based organizations and mental health consumers.
8. Volunteer in community efforts (for example, in homeless shelters) to demonstrate the hope and reality of recovery—and to give back to the community.
9. Generate publicity for the positive role that faith communities play in the recovery of persons with mental illnesses.
10. Create and disseminate templates for consumer letter-writing campaigns to clergy and lay leaders of faith-based organizations.
11. Encourage consumer participation at all levels of planning, research, education, program development, and policy.
12. Mobilize consumer groups to prepare reference manuals on mental health and other social support resources in their communities for the benefit of clergy, schools, and other groups.
13. Promote consumer participation on governing boards and committees of faith communities.

These recommendations may serve as a menu for agencies, organizations, and individuals who wish to adapt the ideas for implementation in their own communities.

Conclusions

Participants ended the dialogue by expressing optimism about the positive impact that mental health consumers and members of faith-based and community organizations can have by working together. The dialogue itself was a unique opportunity, both enlightening and inspirational to everyone who attended.

The participants stated their hope and expectation that readers of this monograph can use the dialogue's findings and recommendations to create partnerships in their own communities. These partnerships can build supportive environments that promote recovery for individuals with mental health disorders and at the same time educate clergy, congregations, and members of the community at large about mental illnesses. Partnerships can reduce discrimination and stigma attached to mental illness. Partnerships can foster hope and help for everyone who experiences mental illness.

*"There is great opportunity in this country for community and faith-based organizations to contribute in new and profound ways."
(Faith community worker)*

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President George W. Bush's Message on the Faith-Based and Community Organization Initiative (Excerpts)

*Faith-Based and Community Organization Initiative
(Executive Orders Signed January 29, 2001)
“Rallying the Armies of Compassion”*

America is richly blessed by the diversity and vigor of neighborhood healers: civic, social, charitable, and religious groups. These quiet heroes lift people's lives in ways that are beyond government's know-how, usually on shoestring budgets, and they heal our nation's ills one heart and one act of kindness at a time.

The indispensable and transforming work of faith-based and other charitable service groups must be encouraged. Government cannot be replaced by charities, but it can and should welcome them as partners. We must heed the growing consensus across America that successful government social programs work in fruitful partnership with community-serving and faith-based organizations—whether run by Methodists, Muslims, Mormons, or good people of no faith at all.

The paramount goal must be compassionate results, not compassionate intentions. Federal policy should reject the failed formula of towering, distant bureaucracies that too often prize process over performance. We must be outcome-based, insisting on success and steering resources to the effective and to the inspired. Also, we must always value the bedrock principles of pluralism, nondiscrimination, evenhandedness, and neutrality. Private and charitable groups, including religious ones, should have the fullest opportunity permitted by law to compete on a level playing field, so long as they achieve valid public purposes, like curbing crime, conquering addiction, strengthening families, and overcoming poverty.

In this blueprint, I outline my agenda to enlist, equip, enable, empower, and expand the heroic works of faith-based and community groups across America. The building blocks are two Executive Orders . . . that call for the

creation of a high-level White House Office of Faith-Based and Community Initiatives, and instruct five Cabinet departments to establish Centers for Faith-Based and Community Initiatives. . . .

In social policy, the nonprofit sector—secular and religiously affiliated providers, civic groups, foundations, and other grant-givers—has long been a vital and valued partner of government. We honor both nonprofit agencies and government programs. We seek to add to, not take away from, their good work.

We will focus on expanding the role in social services of faith-based and other community-serving groups that have traditionally been distant from government. We do so . . . because they typically have been neglected or excluded in Federal policy. Our aim is equal opportunity for such groups, a level playing field, a fair chance for them to participate when their programs are successful. We will encourage Federal agencies to continue to become more hospitable to grassroots and small-scale programs, both secular and faith-based, because they have unique strengths that government can't duplicate.

Faith-based and grassroots groups that achieve good results should be eligible to compete for Federal funds. And the Federal Government should do more to encourage private giving—from individuals, corporations, foundations, and others—to the armies of compassion that labor daily to strengthen families and communities.

This initiative is . . . designed to make sure that faith-based community-serving groups have a seat at the table. It will eliminate the Federal Government's discrimination against faith-based organizations, while also applauding and aiding secular nonprofit initiatives. It will reach out to grassroots groups without marginalizing established organizations. America has a strong, thriving nonprofit sector. Recent figures indicate that the 1.4 million organizations comprising the independent sector receive over \$621 billion in total annual revenue, representing 6 percent of the national economy. Charities and other nonprofits employ over 10 million individuals, comprising over 7 percent of the American workforce.

Without diminishing the important work of government agencies and the wide range of nonprofit service providers, this initiative will support the unique capacity of local faith-based and other community programs to serve people in need, not just by providing services but also by transforming lives.

Our faith-based and community agenda will be organized around three lines of action:

- ◆ Identifying and eliminating improper Federal barriers to effective faith-based and community-serving programs through legislative, regulatory, and programmatic reforms;

- ◆ Stimulating an outpouring of private giving to nonprofits, faith-based programs, and community groups by expanding tax deductions and through other initiatives; and
- ◆ Pioneering a new model of cooperation through Federal initiatives that expand the involvement of faith-based and community groups in after-school and literacy services, help the children of prisoners, and support other citizens in need.

See www.whitehouse.gov/news/reports/faithbased.pdf for the full text of President Bush's message.

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Federal Resources

U.S. Department of Health and Human Services
Center for Faith-Based and Community Initiatives
www.hhs.gov/fbci

Substance Abuse and Mental Health Services Administration
www.samhsa.gov/faithbased

SAMHSA's National Mental Health Information Center
www.mentalhealth.samhsa.gov
(800) 789-2647

Private Resources

Resource Center to Address Discrimination and Stigma
www.adscenter.org/resources/faith.shtml
(800) 540-0320