

A MENTAL HEALTH GUIDE & RESOURCES FOR CLERGY

Introduction

Sadly, despite miraculous scientific advances in treatment over the last two decades, pervasive shame and stigma still surround the subject of mental illness. Because of society's negative stereotypes, many people experiencing psychological distress turn to their *clergy* before seeking mental health services. While some clergy do have training in pastoral counseling, most will need to refer individuals elsewhere for mental health treatment. Further, despite inadequate preparation or guidance, clergy are increasingly encountering persons in the midst of a psychiatric crisis.

Understanding how to make a successful referral is certainly the first step toward promoting an individual's recovery; however, there are many additional ways clergy and congregations can continue to support the recovery and well-being of congregants and community members. As natural circles of caring and support, acceptance and fellowship, faith communities can be especially helpful to those struggling with serious emotional and psychological challenges, as well as a support to their families and loved ones.

This publication offers a basic guide to understanding and responding to a mental health crisis, along with practical suggestions for supporting individuals living with chronic and challenging mental illnesses. In it, you will find helpful suggestions for appropriate responses to specific emergency and non-emergency situations. A list of community resources for treatment and support accompanies the guide, and internet and print resources containing ample information on mental illnesses, treatment, and recovery are also referenced.

Contributing to an individual's recovery and reintegration into community is both spiritually and emotionally gratifying, and best exemplifies caring for the "least of us." In *Souls in the Hands of a Gentle God*, Reverend Craig Rennebohm and David Paul¹ provide an excellent discussion of the beneficial role that clergy and faith communities can play in supporting mental health recovery. Appreciative of the possibilities of faith-based mental health support, Mental Health America of the Central Valley offers this guide for providing hope and healing for persons with mental health challenges, their families and their friends.

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EMERGENCIES: WHEN DO I CALL 911 ?

Call 911 whenever you believe that an individual is:
1) a danger to him/herself,
2) a danger to others, or
3) gravely disabled

But, what do these terms actually mean? And what do I do in the meanwhile?

1. “**Danger to self**”- the individual . . .

- is (or has recently been) thinking about ending her/his life; and
- has a plan for how to do it; and
- has the means readily available

Likewise, a person talking about self-harming or evidencing self-harm (apparent burns, scars, and other inexplicable wounds) is a danger to self. If you aren't sure, do not hesitate to call 911. The response team is trained to make that determination.

What to do next . . .

Stay with the individual at all times and prevent access to anything with which s/he could injure her/himself (weapons, sharp tools, medications, poisonous substances, etc.). Remain calm and reassure that help is forthcoming and hope is realistic. Give all known information to the responding police and emergency personnel, particularly if you know what medications the person is taking. If known, possible, and prudent, alert family members that you have called for emergency support. Be aware, however, that an adult (18+ yrs.) has the right to keep this information from family and friends. **You do have the right, and responsibility, to call 911** should you believe an individual is in imminent danger or capable of harming another.

2. “**Danger to others**” – the individual is . . .

- physically combative
- talking about wanting/planning to injure or attack another
- threatening property (i.e., *blowing up a house, smashing a car, etc.*) or expressing the fear (or appearing) that s/he is out of control and likely to become violent

What to do next . . .

Stay a safe distance from the individual. Offer food, drink, or a “smoke” if appropriate, and a place to rest quietly, away from others, until help is available. If you become aware of a threat to a specific individual, named or relational (or a threat to that person's property) **notify law enforcement** so that the proper steps can be taken to protect the potential victim. Do not assume this will be done by someone else.

3. “**Gravely disabled**”

The gravely disabled individual is disoriented and/or lacks the ability to provide his/her own food, clothing and/or shelter. Being gravely disabled is considered a health hazard. Unfortunately, this designation applies only when the individual's needs are due to a mental illness and not due to poverty alone.

What to do next . . .

Offer to help the individual find care. Provide a quiet, safe place to rest and refreshment while waiting for the emergency responders.

I've called 911 . . . now what happens?

911 will bring Law Enforcement trained to assess the individual and situation and, if appropriate, write an application for a "5150" (72 hour hold). If deemed necessary, Law Enforcement will call for an ambulance to transport the individual to the local hospital emergency room for a medical/clinical evaluation.

The individual may be stabilized and released with follow-up instructions, or hospitalized (the 5150 hold) for 72 hours for further evaluation and/or treatment. After the 72 hours, a longer hold may be subsequently applied if necessary. In this case, a medical/judicial hearing is held during which the individual *must* be represented by a *Patients' Rights Advocate*² and *may* have family members present.

A "Different Kind" of Emergency: Co-Occurring Disorders and the Prison System

Research has demonstrated that mental illness and Substance Use Disorder frequently co-occur. Close to 50% of those diagnosed with Substance Use Disorder have an underlying serious mental illness that has not been diagnosed or adequately treated. Nearly 50% of those with a mental illness also meet the criteria for Substance Use Disorder.

As untreated individuals become addicted to mood altering substances, they are more likely to engage in criminal behavior. However, some persons suffering a serious mental illness - without substance use - may encounter confrontations with the law (i.e., attempts at self-harm, inappropriate, reckless or aggressive behavior, threats, property damage, etc.)

DISPELLING THE MYTH OF THE MENTALLY ILL BEING "MORE VIOLENT":

1. The proportion of those with mental illnesses who commit crimes is no greater than in the general population, yet mental illness is increasingly singled out in the media.
2. Persons with serious mental illnesses are actually at much greater risk of becoming victims of criminals who take advantage of them.
3. When someone with a mental illness or co-occurring disorder *is* jailed, it is often a result of the long term lack of community support for preventative treatment. As public mental health services have diminished, jails have become the largest "providers" of inpatient mental health services.

For a compelling exposé of mental health and the criminal justice system, see *Crazy: A Father's Search Through America's Mental Health Madness* by Pete Earley³, an award-winning journalist whose year-long study of the Miami-Dade County Jail was inspired by his son's first psychotic episode and arrest.

If someone you know has been arrested, the Patients' Rights Advocate in your county can help you with information as to the individual's rights to treatment, and how to provide important information to the appropriate officials.

Confidentiality and HIPAA

Confidentiality law prevents medical personnel or Law Enforcement from sharing adult patient information with *anyone* without a written authorization signed by the patient and a witness, naming the specific party(ies) to receive the information and defining what information may be shared (i.e., assessment, diagnosis, treatment plan, etc.)

While protecting an individual's important right to privacy, this protection can be a major barrier to a family member, close friend, clergy or church staff who *could* support the individual's follow through with treatment and appointments, if patient information were known to that support person

When the crisis is over, talk about the value of preparing an authorization for the release of patient information (an example follows in the appendix), legally entitling the treating facility and provider(s) to provide patient information to a designated recipient. If the person is agreeable, have him/her fill out the form, sign and date it (it must be witnessed by someone other than those named) and provide the designated recipient(s) with a copy or two. In the event of another crisis, a copy of the authorization goes to the hospital with the emergency responders, and a copy stays with the designated recipient(s) for confirmation.

An individual may and is certainly entitled to object to signing a release. It is possible, however, s/he may have a change of mind after becoming more comfortable within the faith community. Trust takes time to develop, but clergy and congregational support team members can be trusted as much as family and friends.

The Importance of Aftercare

Even when stabilized and released from a short-term crisis or longer-term inpatient hospitalization, a person recovering from an episode of mental illness often needs continuing support to follow through on after-care. Shame about loss of self-control compounds the already existing mental health problem. Making and attending treatment appointments, taking medication(s) correctly, and participating in structured social supports are all important for regaining stability and maintaining recovery.

Frequently however, like many of us who have "skimped" on taking the *full* course of antibiotics, mental health consumers, once beyond the immediate crisis, may become less diligent about or even resistant to following through on their treatment plan. Failing to adhere to medication and therapy unfortunately often results in relapse; each relapse compounds the difficulty of recovery.

Public systems well understand the need for assisting clients with managing their treatment. A variety of personal services, case-management and peer support positions have been designed to fulfill this role. Reduced budgets, however, have impacted staffing to the degree that such services are now more ideal than real.

The Faith Community and Aftercare

The faith community can be particularly helpful in bridging the gap between the consumers and their services. Trusted clergy can reinforce the importance of following the treatment plan as prescribed, assist with transportation, offer encouragement, and (most important) emphasize discussing *any* changes in medication or treatment with the provider first, before unilaterally making decisions to change or stop treatment.

Some faith communities have developed a cadre of lay "mental health ministers" or point persons, trained to assist members needing support for maintaining their mental health. In large congregations, clergy may find it helpful to pair a vulnerable individual with a compassionate "check-in buddy" who will maintain regular contact in the period after the crisis, and facilitate the individual in developing a stable support system.

These “ministers,” familiarized with local public and private agencies offering treatment and support, can help consumers navigate the complex systems and services available to them.

NON-EMERGENCIES (& REDUCING FUTURE OCCURRENCES)

Many resources are available to consumers who need support but are not currently in crisis; however, resources are, literally, *all over the place*, each has its own “target population”, and each maintains its own set of eligibility criteria. Public mental health, not-for-profit community based agencies, clinics, colleges and faith communities offer an array of mental health, substance use, and co-occurring disorder interventions. Some private providers accept a limited number of low fee clients.

Finding the right resource can be daunting for a person in the best of health; for an individual in crisis or dealing with a chronic illness, it is simply overwhelming. Using this guide to do a bit of advance “legwork” for the individual can greatly improve the probability that the most appropriate help available will be accessed. Assisting with setting up the first appointment, offering a ride, or accompanying the individual on the bus to the first session or two can greatly reduce the fear of taking that first step toward recovery.

What if the individual rejects needed support?

Most of us are resistant to admitting the need for help, that our lives may be out of control, or that we are not living up to our (and/or others’) expectations. Often, individuals will seek help during an immediate crisis, only to drift away once the immediate issue has passed. Mental health treatment may be perceived as threatening, embarrassing, too difficult, or simply “unnecessary”.

Some illnesses actually impair a person’s insight, the cognitive ability to recognize the reality of the illness and the need for treatment. Psychotic illnesses can cause delusional fear and paranoia leading consumers to misinterpret good intentions as sinister “plots” to control or hurt them.

For a “user-friendly,” pragmatic understanding of how and why psychotic illnesses can undermine adherence to treatment - plus excellent suggestions for communicating with very ill individuals - see *I’m Not Sick: I Don’t Need Help*, by Amador Xavier, Ph.D.⁴ Another more comprehensive (yet completely readable) resource on schizophrenia, treatment and current research is found in *Surviving Schizophrenia: A Manual for Families, Patients and Providers*, 5th edition, by E. Fuller Torrey, M.D.⁵, a national expert on this baffling disease.

For most persons experiencing mental health related symptoms, however, non-judgmental listening to the reasons and concerns preventing an individual from seeking or accepting treatment can be extremely helpful. It may be cost, transportation, fear of side effects, lack of education, discomfort with the provider, feeling judged, or something entirely different. Listening without contradicting or pushing,

asking open-ended questions, reflecting back what you hear, and showing concern, can help a frightened or resistant individual begin to assume responsibility for his/her own care.

If acceptable to the individual of concern *and the provider*, you may offer to attend the first (or another) session to help voice concerns, and to discuss how the three of you may work as a team. Public mental health workers across California are receiving training in cultural competency, which includes understanding the importance of spiritual care to mental health. Many providers are comfortable working collaboratively with faith leaders.

Clergy's personal values and beliefs about mental illness and treatment will be perceived and modeled by congregants. Please learn as much as you can about illness and recovery so that the hope of healing you extend is supported by treatment as well as faith. *Your* commitment to the benefit of, and adherence to, treatment is extremely important. Further, you can help individuals recognize the downward spiral resulting from failure to adhere to treatment and repeated relapse, and empower them to be active participants in their recovery. Finally, faith leaders can guide consumers in developing personalized wellness and crisis plans⁶.

What about ongoing faith community support?

- Be a welcoming congregation; invite individuals with mental health conditions to attend services regularly and participate in social, educational and ministry activities (see *Rev. Susan Greg-Schroeder's* internet publication entitled *Mental Illness & Families of Faith: How Congregations Can Respond*)⁷.
- Publish a regular mental health article in your monthly newsletter, addressing various topics (diagnoses, treatment, wellness & recovery, resources)
- Develop a cadre of caring congregants who can be trained as “mental health ministers” to provide support, encouragement, and navigation assistance for consumers needing private or public services
- Assign a “buddy” to the consumer, who will call her/him weekly with reminders of services or meetings
- Pair consumers who have no family/friend support with a willing family for holiday celebrations
- Reassure the individual that her/his illness is “no fault,” there is no blame, and there should be no shame in needing and asking for support
- Offer support and referrals to the individual's family, even if the individual him or herself is not a member of the congregation
- Dedicate at least one service each year to mental health – consider inviting guest speakers

- Encourage and host a peer support group such as a *DBSA (Depression and Bipolar Support Alliance) Group*⁸ and identify a clinician, doctor or nurse in the congregation who would be willing to serve as its advisor.
- Youth – incorporate mental health into your religious education curriculum, frankly addressing early onset symptoms and treatment, stigma and discrimination. Start a support group for parents of children with mental health or other brain/behavior disorders

A few things to avoid . . . please . . .

- avoid the implication of blame toward the ill individual or his/her family relations. Mental illnesses have a biological basis which, even when occurring in the best of families, often disrupt harmony and result in unexpected, distressing and unaccepted behaviors. On average, obtaining an appropriate diagnosis takes 7-10 years from the time of first onset of the illness. With half of all severe mental illnesses having their onset prior to age 14, most families will struggle to “survive” for years without support. Encourage family members to seek help for themselves as well as the affected individual⁹.
- avoid offering or implying an arbitrary timeline (i.e., “You’ll feel better tomorrow, next week, next month, etc.) or a bargain (if you will just do - - -, you’ll feel better). Mental illnesses are very treatable, but may not respond immediately, or to the first intervention. Be encouraging, but realistic, by offering support and hope, i.e., *“I know you will feel better, but it takes time and effort in many different areas. Let’s plan together what you might want in your “tool bag” for your journey to recovery, and know that you are not traveling alone.”*
- avoid implying that prayer alone can heal the mental illness. Encourage prayer as a helpful “tool”, but *not* as a substitute for treatment. Many individuals have suffered for years, despite fervent prayer and worship service attendance. Once they have received treatment and have improved, the memory of being advised to “pray harder” is so painful, they tend to turn away from their faith community - a loss to the faithful individual and congregation alike.
- Avoid implying that someone should be able to pull him/herself up out of a despondency. Mental health research indicates that it is not possible to “will” oneself to mental health any more than it is to cure one’s cancer or diabetes with attitude alone. Serious mental illnesses are medical conditions. Recovery requires multi-modal treatment (often including medication), education, social *and* spiritual support.

A FINAL NOTE

Although we still have lots to learn about what actually causes the outbreak of a mental illness, we do know much about risk factors. High stress, lack of support, social isolation and inadequate self care are among the risk factors for a first onset or relapse. Clergy are not immune to these stressors, especially as they become more deeply engaged in caring for the most vulnerable. Practicing what you preach, i.e., taking the very *best* care of your own mental health, will keep you in shape to assist others! But remember, at some point in our lives, clergy or not, many of us will need to seek our own mental health support.

Notes:

¹ Rennebohm, Rev. Craig and Paul, David. *Souls in the Hands of a Tender God: Stories of the Search for Home and Healing on the Streets*. Massachusetts: Beacon Press, 2008.

² Patients' Rights Advocate: California: (916) 575.1610, Fresno: (559) 253.2238

³ Early, Pete. *Crazy: A Father's Search Through America's Mental Health Madness*. New York: G.P. Putnam's Sons, 2006.

⁴ Amador, Xavier. *I Am Not Sick; I Don't Need Help*. New York: Vida Press, 2007.

⁵ Torrey, M.D., E. Fuller. *Surviving Schizophrenia: A Manual for Families, Patients, and Providers*, 5th ed. New York: HarperCollins Publishers, 2006.

⁶ Copeland, PhD, Mary Ellen, and Mead, Shery, M.S.W. *Wellness Recovery Action Plan & Peer Support: Personal, Group and Program Development*. Vermont: Peach Press. Also, visit her website: Mary Ellen Copeland: Mental Health Recovery and WRAP (<http://www.mentalhealthrecovery.com>) for additional helpful self-help publications.

⁷ Greg, Schroeder, Rev. Susan. *Mental Illness and Families of Faith: How Congregations Can Respond Resource/Study Guide for Clergy and Communities of Faith*. Downloadable from the Internet at: www.mentalhealthministries.net, 2010.

⁸ DBSA – Depression and Bipolar Support Alliance. Online at <http://www.dbsalliance.org>. DBSA provides excellent instructions and a resource manual for developing a peer support group as small as three regular members. Click the Find Support/Start a Support Group link from the sidebar on the left.

⁹ Mental Health America (MHA online: <http://www.nmha.org>) and National Alliance for Mental Illness (NAMI online: <http://www.nami.org>) have local chapters which offer peer/family education and support. Also, check your local county mental health department for wellness and/or drop-in centers.

APPENDIX

(Example) AUTHORIZATION FOR RELEASE OF INFORMATION

To: *print name / address of receiving agency, hospital or provider*

Re: _____
print client name

Date of birth: _____ Social Security No: _____

I, _____,

authorize the above named person(s) or agencies to release information to and exchange information with the following person(s):

_____/_____
Print name relationship to me

_____/_____
Print name relationship to me

The information to be disclosed is related to my assessment, diagnosis, and treatment plan for the purpose of planning, enhancing and supporting the quality of my services and treatment.

I have read and understand the above statement. I consent to the disclosure of the above information. I may at any time submit a written or verbal request to withdraw my consent.

A COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

This authorization shall be in effect for one year from the date of my signature unless otherwise stated:

Client Signature date

Witness Signature date
(Witness must be an adult other than the individual(s))