

Welcomed and Valued



*Building Faith Communities of Support and
Hope with People with Mental Illness
and Their Families*

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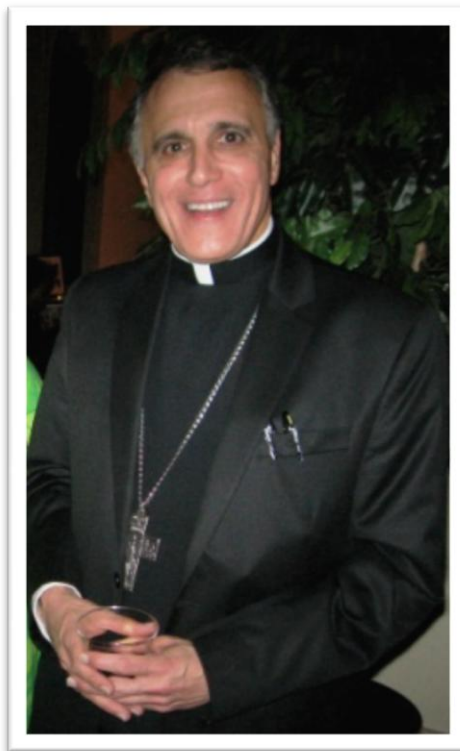
Cover Logo —The cover logo depicts the Eucharistic table, to which all are called. It also presents four dimensions to personal wholeness, each important to healing and recovery—spiritual, biological, psychological, and social.

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Cardinal Daniel DiNardo, Archbishop of Galveston-Houston, praises this effort of the NCPD Council on Mental Illness:

“As Episcopal Moderator of NCPD, I fully endorse this important and necessary venture, to help parishes welcome, include and serve the spiritual needs of Catholics with mental illness. Fundamental to all our work is honoring the life and dignity of the human person, regardless of circumstance, as affirmed in the 1978 *Pastoral Statement of U.S. Catholic Bishops on People with Disabilities*. We are all part of the Body of Christ. I applaud this well-designed effort by the NCPD Council on Mental Illness, and encourage clergy, parishes and dioceses to make every effort to participate in one of these programs.”



A Parishioner Speaks: Kay's Story

1995

*Dark, evil forms slither across like black swans
Engorging themselves on my body, my soul, my very being.
Where is their nemesis?
How can I fight them?
Help me.
(Kay)*

2001

*"Feels that no one loves her.
Not anyone.
Not husband.
Not children.
Not anyone.
Has no friends."
(Notes: John Grebe, PsyD)*

2005

*"My soul doth magnify the Lord,
And my spirit rejoices in God my Savior.
For He who is mighty has done
great things, and holy is His Name."
(Luke 1:47, 49)*

For eight years, inexplicable pain, fear, and self-hate had a death grip on me. I recently found suicide letters I had written to my six children, more recently, I found another set.

Among "my people," I found we receive the most stigmatization from our churches! I remember sitting in the hospital, huddled in a little group of about six, when one of us received a visit from her pastor. The rest of us sat there and related things like, "my pastor never visits me, no one from the church visits me, I've never even received a card from my church, let alone visits or flowers, etc." If it wasn't for the hospital chaplain, we would have had no prayer, no affirmation. We weren't

abandoned by God, just by our churches. Because of the stigma, I observed, experientially, we are not prayed for during the Prayers of the Faithful, as those having surgery, or enduring other physical disorders. Lack of education about mental illness, as well as apathy, is at the core of this painful abandonment.

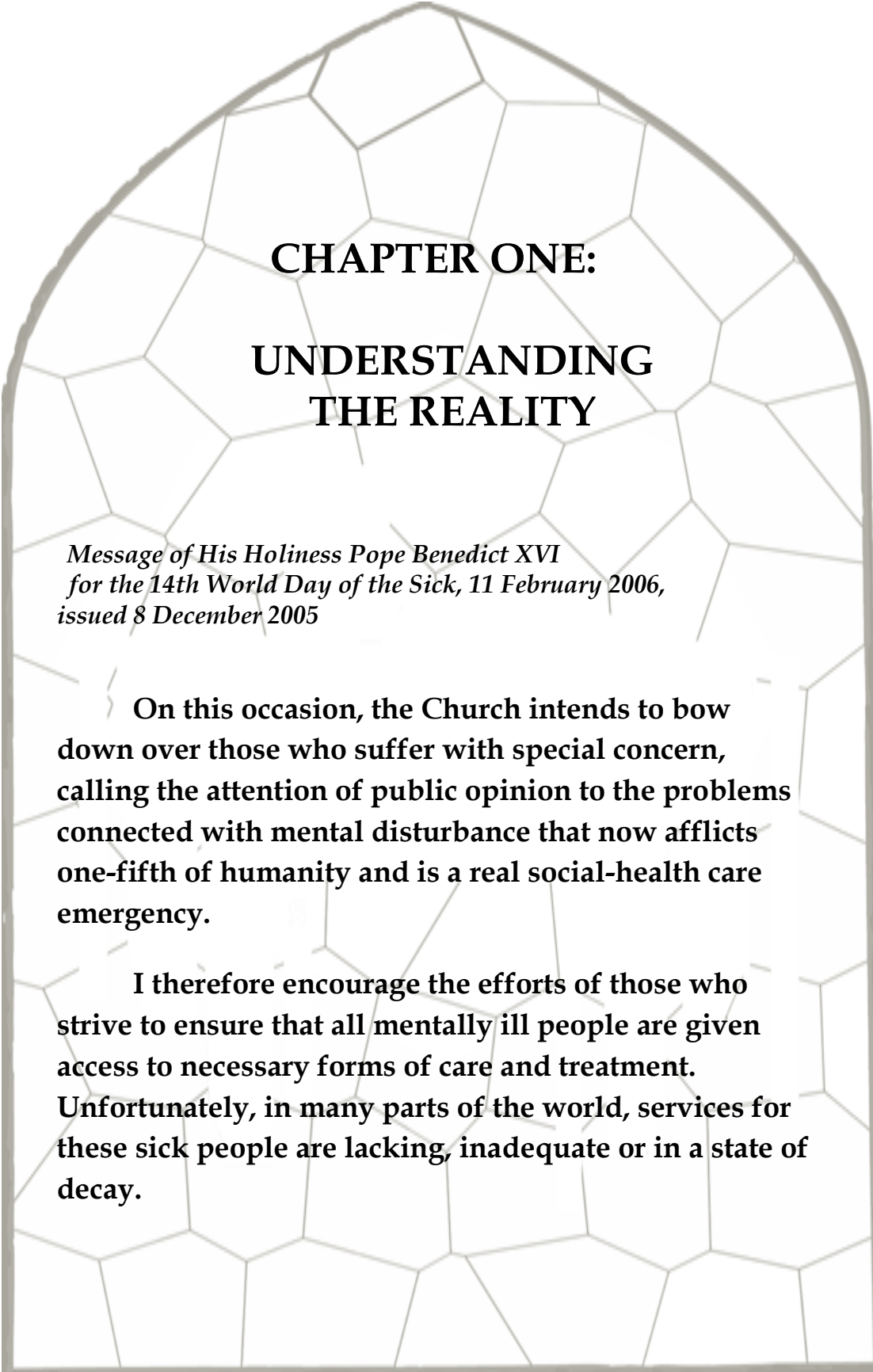
A number of my friends with mental illness tell me they fear going to church—for fear someone will find out. How can it be that a church is not a “safe” place—a sanctuary for those who need respect, dignity, affirmation, prayer, and hope for recovery—a place where a wounded soul can find the Body of Christ in Eucharist, and in skin. We are not our diagnosis. We, too, have gifts and talents to be shared.

You need to understand our serious needs. This manual prepared by the Council on Mental Illness of the National Catholic Partnership on Disability will help you. My prayer is that all pastors, deacons, and parish staff, study groups, individuals will read this book and share it with others.

-- Kay Hughes



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CHAPTER ONE: UNDERSTANDING THE REALITY

*Message of His Holiness Pope Benedict XVI
for the 14th World Day of the Sick, 11 February 2006,
issued 8 December 2005*

On this occasion, the Church intends to bow down over those who suffer with special concern, calling the attention of public opinion to the problems connected with mental disturbance that now afflicts one-fifth of humanity and is a real social-health care emergency.

I therefore encourage the efforts of those who strive to ensure that all mentally ill people are given access to necessary forms of care and treatment. Unfortunately, in many parts of the world, services for these sick people are lacking, inadequate or in a state of decay.

Defining the Need

There is high prevalence of mental illness in every faith community. One in five families has a member with a diagnosable mental illness. One in seventeen people lives with a persistent or severe mental illness. Often individuals or families turn to their parish community for support and guidance. Regrettably, some parishes fail to respond due to limited understanding of mental illness or lack of awareness of the power of supportive relationships. Yet one cannot deny the role that faith communities can play in providing the understanding and compassionate support essential to recovery and living daily with this challenging illness.

People who experience major mental illnesses tend to feel isolated and marginalized. They often feel excluded from the community in which they grew up and from their own parish. The myths about and the misunderstanding of mental illness keep some people and their families from participating in the life of the church because they feel judged, devalued, unwelcome, or

People who experience major mental illnesses tend to feel isolated and marginalized. They often feel excluded from the community in which they grew up and from their own parish.

“different.” Awareness of these perceptions, which are often overlooked or discounted, can guide parishes in the most helpful response. Including people with mental illness and their families in addressing these issues will provide insights into the most effective response.



The onset and subsequent diagnosis of mental illness impacts families as well as the individual. Families with a member with mental illness often do not know where to turn for help. Understanding and coping with the illness, as well as the search for services and support, drains them spiritually, physically, emotionally, and financially. Often relationships with extended family members and friends are strained. The illness itself and the associated stigma of mental illness can lead to feelings of guilt, denial, grief, isolation and loss of hope.

People who live with mental illness are disproportionately impacted by the social injustices of prejudice, poverty, inadequate housing, unemployment or underemployment, lack of access to health care, especially mental health care, and inequalities within the criminal justice system. Each issue demands advocacy to ensure that the needs of people with mental illness are effectively addressed.

Serious mental illness can cause a crisis of faith for the person with mental illness and for the family. Why me/why our family? Is God punishing me/us? These and other questions can shake one's faith and be obstacles to recovery. A supportive faith community can help work through doubts and questions in a way that contributes to recovery and a restoration of faith.

An informed and caring faith community is an integral part of the holistic support system that provides companionship and hope to people living with mental illness, and to their families.



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Transforming Perceptions

The entire ministry of Jesus was about transforming perceptions—revealing the truth and infinite value of each person against the stereotypes and alienating perceptions that divide and marginalize people.

“Blessed are you poor in spirit...” Matt. 5:3-12

“Let the children come to Me...” Mark 10:13-16

“A Levite....passed by on the other side of the road....A Samaritan.....had compassion...” Luke 10:29-37

“As he passed by, he saw a man blind by birth.....who sinned, this man or his parents.....It was not this man, or his parents but that the works of God might be made manifest in him...” John 9:1-41

“Teacher, this woman has been caught in the act of adultery.....Let him who is without sin among you be the first to throw a stone at her.” John 7:53 - 8:11

“If a man has a hundred sheep, and one of them has gone astray, does he not leave the ninety-nine...Rejoice with me, I have found my sheep that was lost.” Luke 15:3-7

“You have heard it said, ‘Love your neighbor and hate your enemy’ but I say to you, love your enemies and pray for those who persecute you...”Matt 5:38-48

““The wedding is ready, but those invited were not worthy. Go therefore to the thoroughfares, and bring in the poor and maimed and blind and lame....” Luke 14:15-24

Jesus’ penetrating questions disarm righteous attitudes and expose hypocrisy and prejudice. Today, God’s grace is at work challenging our perceptions of each other and guiding us to regard each person with love that has no conditions.

In our parishes are people who live daily with mental illness, at times not evident, and at other times experiencing episodes that disrupt every aspect of life, particularly relationships. Most basic in making a difference in the lives of parishioners with mental illness is a loving regard for the person that seeks to better understand the challenges of the illness, accompanying the person in whatever way

possible to communicate that they are not alone on this journey through healing and recovery.

All human life is sacred. Every person created in God's image, reflecting the likeness of God is deserving of utmost respect and dignity even in the midst of episodes of illness. Nothing can diminish that dignity and worth, not mental illness or any condition. Each person is a significant contributor to the wholeness of the Body of Christ forming a community of faith that celebrates each other's joys and bears each other's burdens. The compassion and love that marks the followers of Jesus must be evidenced in the Church's regard for all members of the Body of Christ whose lives are challenged by this illness. Praying for the grace to love as Jesus loves, to grow in understanding, to be a companion to those in need of acceptance and support is the beginning of perceptions transformed.



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Mental Illness Basics

Mental illness, as commonly understood, is the improper functioning of the brain, the most complex of all organs of the human body. Such illnesses are characterized by alterations in thinking, mood, or behavior (or some combination thereof). Mental illness may occur at any age, with the initial onset of some types of mental illness manifesting in particular age ranges. For example, the onset of schizophrenia or bipolar disorder is particularly prevalent in the teenage years and early adulthood. Mental illness is also indiscriminate of gender, race, or socioeconomic background.

Our understanding of mental illness, and mental health, is constantly changing and expanding. However, at present, there are several key facts that are known. A mental illness: (a) may involve a number of different conditions; (b) can occur at any age to anyone; (c) manifests itself in a range of severity; (d) is cyclical in nature; and (e) encompasses biological, psychological, social, and spiritual dimensions of the individual. According to *Mental Health: A Report of the Surgeon General*, an estimated 22 to 23 percent of the U.S. population experiences a mental disorder in any given year, but almost half of these individuals do not seek treatment (U.S. Department of Health and Human Services, 2002; U.S. Surgeon General, 2001).

Of these, approximately 6%, or 1 in 17 individuals experience a severe and persistent mental illness. These illnesses are constant or frequently recurring, and significantly interfere with one's ability to function in family, job, school, community. These severe and persistent mental illnesses include:

- Schizophrenia;
- Bipolar disorder (manic-depressive illness);
- Schizoaffective disorder or some types of major depressive disorder;
- Obsessive compulsive disorder (OCD);
- Post-traumatic stress disorder (PTSD).

Certain other conditions, although they may co-occur, are mistakenly understood as mental illness: intellectual disabilities, dementia (Alzheimer's, vascular), and substance use disorders (drug/alcohol abuse and dependence).

Similar to other health conditions, proper diagnosis and treatment are critical in ensuring that the individual's mental health needs are properly addressed. Treatment of a mental illness may consist of medication, psychotherapy, or counseling (alone or in combination). Along with the various treatment modalities available, an individual's social well-being through positive family support, employment, friends, and hobbies are equally important in providing the appropriate care required by an

individual. One must acknowledge that the treatment objective of mental illness does not necessarily involve the eradication, i.e., cure, of the condition, but rather its on-going management so as to minimize the adverse effects of the mental illness on the everyday functioning of the individual.

Stigma, i.e., bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance of persons diagnosed with mental illness contributes to the impact of the illness, and imposes substantial hurdles that must be overcome to ensure proper care and treatment. Unfortunately, research shows that nearly two-thirds of all people with diagnosable mental illnesses do not seek treatment. In many instances, failure to seek treatment results from the stigma associated with having a mental illness. With community education, comprehensive care and treatment, many individuals are relieved of suffering and experience improvement in functioning and quality of life.



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Children/Youth and Mental Illness

Katie's story: My Dad died of cancer when I was 8 years old. The long-term effect of my dad's death was not only processing grief but learning to live with the resulting anxiety that followed. If my Dad could die, I feared someone else in my family could die too. The fear and anxiety produced physical reactions of stomach aches and vomiting. When my Mom got sick, my fear that my Mom might die caused me to be sick. I feared anything that potentially threatened the well-being of my family. In time, even normal reactions of anxiety (i.e., before a test, giving talks at school) triggered upset stomach and vomiting. I was beginning to feel anxiety about the anxiety. I couldn't think of staying overnight at a friend's house for the very reason that I might get anxious about something and throw up. Thankfully, over time, with the support of my family and friends, medicine that helped my anxiety, and my faith, I am now able to face everyday situations without undue fear. It is only now as an adult that I can look back and see the impact this had on my life as a child.

- Anonymous contributor

Mental Health Issues of Childhood

The report of the Surgeon General reveals about 20% of U.S. children live with a diagnosable mental illness. Of those, nearly 5 million American children and adolescents live with a serious mental illness that significantly impacts their everyday life—resulting as well, in a significant impact on the life of their families. Diagnosis of a mental illness for children can be difficult. Children differ from adults in that they experience many physical, mental, and emotional changes as they progress through their natural growth and development. A diagnosis of mental illness must consider how well a child functions at home, with his/her family, at school, and with peers as well as the child's age and symptoms.

Children with emotional difficulties are often perceived as children who are misbehaving, and their parents may be judged as incapable of managing them. Understanding that this behavior may be due to mental illness can transform a once judgmental attitude to one of compassion and support needed by children and their families. When children exhibit aggressive or atypical behaviors, many parents feel confused, guilty, and blame themselves. They may feel at a loss about what to do, not yet recognizing that their child may need an evaluation by a mental health professional.

Parents facing these challenges may need guidance and support on what to do, and how to access mental health services. The local community mental health agency and chapter of the NAMI (National Alliance on Mental Illness) offer resources on how to access and navigate the system.

- Parents need to take the child to be evaluated by a mental health professional. The information provided by parents and other significant people in the child's life is important.
- The family, the child, the professional(s) and others invited into the process form a treatment team.
- The pastor or trusted church personnel (e.g., parish nurse, catechist, deacon) may act as advocates and/or guide the family through a complicated system, and be part of the team, if invited.
- If psychological intervention is necessary, a treatment plan is developed to address the needs of the child and family. The plan ought to identify difficulties, steps to improve them, supports needed, and child and family strengths to build upon.
- Effective treatment addresses all the important facets of the child's/family's life, including social, mental, spiritual and physical conditions.
- When medication(s) are needed, it is important to make sure the medicine is taken as prescribed; to note/keep track of positive and negative effects; to have an open and ongoing dialogue with the treatment team.
- The most common treatment modalities to address mental health difficulties are family and individual therapy, skill development, and psychiatric medications. Each helps the child/family learn skills to manage the illness.
- Maintaining church involvement may be extremely helpful in the healing process for the child and his/her family.
- Families need to arrange for respite care to avoid burn out. This is one area where the parish may be able to provide very practical support.
- An awareness of the financial impact of accessing services and psychiatric medications may indicate additional ways the parish can be of support to the family.

Understanding that this behavior may be due to mental illness can transform a once judgmental attitude to one of compassion and support needed by children and their families.

Common Psychiatric Conditions of Childhood/Youth Depression – the main characteristics are a persistent feeling of sadness, lack of hope, thoughts of suicide or

wishing to die, changes in eating (too much or too little) and sleeping too much or not resting, and being withdrawn. Other areas of the youth's life are impacted such as school performance; level of social and physical activity and interaction with friends and family; lack of participation in activities previously enjoyed; increase in irritability and aggression, especially in boys/young men; experimentation with drugs and/or alcohol; and physical complaints. Because of the complexity of these feelings, children may be hesitant to share them with their parents. Sometimes it isn't until after a diagnosis that parents can look back and identify symptoms. Effective current treatment options are medication, cognitive behavioral therapy, and guidance for families to help manage the illness.

If antidepressants are prescribed, it is important that family and the support system such as church and school, be attentive to the behavior of the child/youth for the first couple of months. Many times, children/youth who are depressed do not have the energy to harm themselves; yet as the antidepressants start to work, the youth may not feel any better, but has more energy to act on suicidal thoughts. Antidepressants in general take six to eight weeks to begin taking effect.

Anxiety Disorders – This group of disorders has in common a sense of relentless worries about bad things that may happen. Includes:

- Phobias – fears of specific things such as snakes, darkness, being alone, flying, leaving home, etc.;
- Social Anxiety – fear of being around people;
- Separation Anxiety – fear of being abandoned by caregivers;
- Obsessive-Compulsive Disorder – obsessions are recurring and relentless unwanted thoughts; compulsions are the behaviors done to release the anxiety created by the obsession.

Typically, treatment for anxiety includes a combination of cognitive-behavioral therapy and medications.

Bipolar Disorder – The main characteristic is a drastic change in mood from feeling extreme sadness, suicidal thoughts or wishing death, to an extreme sense of pleasure; usually paired with agitation, irritability, impulsivity, and poor judgment. Medications, therapy and case management are the treatment of choice.

Oppositional Defiant Disorder – This condition involves frequent and consistent uncooperative and hostile behaviors that go beyond the norm when compared to peers, such as refusal to comply with appropriate adult rules and requests, blaming others for his/her mistakes, wanting revenge when feeling hurt. Evaluation by a mental health professional is recommended to rule out other diagnoses. Treatment goals are to

assist the child/youth to learn to respect appropriate limits and increase cooperative behaviors. Treatments indicated are cognitive behavioral therapy, anger management, and social skills training. Parents need a well-designed support system and skills for managing stress.

Conduct Disorder – The main characteristic is a disregard for rules and norms of family and society. The child/youth is perceived as socially inappropriate and difficult. Child/youth exhibits behaviors such as stealing, damaging people’s property, constantly lying, hurting others (humans or animals), forcing others into unwanted sexual activity. The main goal of treatment is to assist the child/youth in recognizing the impact their behaviors have on others and to develop empathy for others. Parents will need a well-designed support system and skills to manage stress.

Main Type of Medications to Treat These Conditions:

- Antidepressants – improve mood;
- Mood Stabilizers – increase the ability to manage mood and help to decrease extreme highs and lows;
- Anti-anxiety – increase a sense of calmness and sense of control;
- Antipsychotic – increase person’s ability to be in touch with reality;
- Stimulants – increase ability to concentrate and are considered controlled substances.

It is important for parents to monitor the effects of medications prescribed to the child/youth, keeping a journal of every medication prescribed to note the positive results and negative side effects. Communicate with the prescribing physician when problems occur. Side effects are a major reason that people do not follow treatment. There are many different choices of medications available to treat the same symptom(s). Medications have different effects on different individuals. Open communication with the treating physician/psychiatrist may make the difference between success or treatment failure.

In light of the significant challenges in the life of a child with mental illness and his/her family it is critical that the faith community become aware of support needs of the child and family, and provide support comparable to how parishioners and pastoral staff typically accompany families of a child diagnosed with a physical illness such as cancer.



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Adults and Mental Illness



My experience of being bipolar—that’s when I’m manic or when I’m high—I talk a lot, just excessively, and I have a grandiose attitude. Not thinking that I’m better than anybody else, but I can do anything. I’ve been in school when I was manic, I graduated from college at 55—it took me a long time between illnesses. I have four children. I can work—I have to work. I can go to school, I can clean house, I can do everything—I’m Superwoman. And then I go down in a pit and I can’t function, I can’t cook, I can’t or don’t want to eat, can’t clean up, hygiene let go, I just cannot function when I go down.

– Coletta Ali

Adults can experience many different mental illnesses; some begin during adulthood, while others represent a continuation of a condition that started in childhood. The experience of mental illness can often be cyclical. An individual may have periods with few or no symptoms and then experience pronounced symptoms. It is important for people to receive an evaluation by a professional so that the proper diagnosis can be made and the appropriate treatment plan can be developed.

Four broad categories of mental illnesses that adults experience are: thought disorders, mood disorders, anxiety disorders, and personality disorders.

Thought Disorders (e.g., Schizophrenia and Schizoaffective Disorder)

Thought disorders, also referred to as psychotic disorders, are conditions that affect an individual’s ability to perceive reality. Symptoms include disorganized thinking, bizarre

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ideas, false perceptions (hallucinations), and strongly held false beliefs (delusions). People with thought disorders also can exhibit disorganized or bizarre behavior, social withdrawal and isolation, and diminished ability to tend to daily activities like eating or personal hygiene. A comprehensive treatment plan addresses the psychological, social, and spiritual dimensions of a person's life. Treatment with medications is almost always required to address the biological aspect of mental illness, reducing or eliminating symptoms and improving the overall functioning and quality of life of the person affected.

Mood Disorders (e.g., Bipolar Disorder, Major Depressive Disorder)

Mood disorders are conditions that involve a significant alteration in a person's emotional state. During periods of depression, people have a low or irritable mood and can have changes in appetite and sleep patterns, feel excessively or inappropriately guilty, have difficulty concentrating or making decisions, and think about death, even to the point of considering harming themselves. In bi-polar disorder, this depression alternates with manic episodes in which people have an elevated or euphoric mood and can have rapid speech and racing thoughts, have an exaggerated sense of their abilities (grandiosity), act in ways that are impulsive and dangerous, and seem to need very little sleep. In extreme periods of depression or mania, an individual can develop symptoms looking identical to those associated with thought disorders. In addition to psychotherapy, family support, and spiritual attention, a variety of medications can be utilized to assist in the treatment of mood disorders.

Anxiety Disorders (e.g., Panic Disorder, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder)

Anxiety disorders include a wide variety of conditions that are characterized by elevated or unexpected levels of fearfulness or discomfort, manifested both physically and mentally. These symptoms are often associated with thoughts and behavior, which temporarily reduce the discomfort, but often result in increased avoidance and isolation. Interventions from biological, psychological, social, and spiritual perspectives each have significant roles to play in a person's management or possible recovery from an anxiety disorder.

Personality Disorders (e.g., Borderline Personality Disorder)

Personality disorders consist of pervasive and inflexible patterns of emotion and perception, which are solidly established by the time a person enters adulthood and which significantly impair a person's ability to interact with other people or to participate in society effectively. Although medications can sometimes help manage associated symptoms, the primary treatment of personality disorders is psychotherapy or other forms of counseling, mindful of the social and spiritual dimensions of the person.

Other Conditions

A variety of other conditions involving intellectual ability, attention, memory, and addiction can affect adults, but generally are viewed as belonging to unique categories, separate from the mental illnesses discussed above.



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Confronting Stigma

Confronting Stigma

In my family, there was mental illness but I never knew it. My grandfather had actually died by suicide in the 1930's, long before I was born, but nobody in the family ever talked about it. I had two aunts who occasionally would go on extended vacations that nobody really talked about and basically they were going for treatment somewhere. Just the fact that my family never talked about the past was due to the stigma. And I think that's an issue for people today still. The stigma is so great, and they say that's one of the issues why people don't get help for either themselves or for their loved ones. They feel they will be judged by society. – *Deacon Tom Lambert*



What Is Stigma?

Stigma, by definition, is a mark of disgrace or shame.

Stigma has four components:

- Labeling someone with a condition;
- Stereotyping people who have that condition;
- Creating a division— a superior “us” group and a devalued “them” group, resulting in loss of status in the community;
- Discriminating against someone on the basis of a label.

How Are Persons with a Mental Illness Stigmatized?

Actions and language that stigmatize can be overt, such as offensive jokes and comments, or subtle such as avoiding a person, withholding a promotion at work, or having low expectations of the person based solely on his/her diagnosis. Unreasonable fears about mental illness can lead to a person's social isolation and low self-esteem. Stigma can mean a person is not taken seriously even about matters that are not affected by their illness.

Why Should I Care?

“One of the fundamental truths of Christian belief is that each human being is created in

the image and likeness of God (Genesis 1:26-27). The Catholic Church unconditionally embraces and faithfully proclaims this truth. It is the foundation for human dignity." *Affirming the Dignity of the Mentally Ill, Nebraska Bishops' Conference 1.05*

At times we unwittingly act and speak in ways that devalue people with mental illness. We must constantly evaluate our attitudes and be vigilant in our efforts to treasure each person as a member of the Body of Christ.

We recognize the cost of stigma to persons and society. Although effective treatment for mental illness exists, it is estimated that nearly two-thirds of the people with these conditions do not seek treatment because of the fear of negative consequences should it become known. Lack of treatment can lead to pressure on marriages, families, friends and relationships in the community.

What Can I Do?

Use "Person-First" language, acknowledging the person before the condition; for example, say "a person with mental illness" rather than "a mentally ill person" or "the mentally ill."

Never use words referring to mental illness as a metaphor. Use of words such as *schizophrenic* and *psychotic* to describe anything other than the medical condition they name reinforces and spreads stigma.

Let persons who use demeaning language or gestures, or engage in humor that trivializes mental illness, know that you find it unacceptable.

Meet fiction with fact. When you hear or see misleading statements about mental illness speak up for the truth.

Give mental illness a voice in our faith communities. Acknowledge the reality that mental illness is a common human condition. Work to create a trusting, accepting community where parishioners are as comfortable sharing about their mental illness as they are about their heart condition or diabetes.



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The Power of Language

“Sticks and bones will break your bones”...and words really can hurt you.

Words are powerful. Even in everyday casual conversation the way we speak about persons, groups and issues affects the attitudes and perceptions of our listeners.

The stigma of mental illness is still alienating and a major barrier to treatment. It is all the more important that our relationships and our language reflect a deep respect for the person and our understanding of the illness.

Words are powerful. Even in everyday casual conversation the way we speak about persons, groups and issues affects the attitudes and perceptions of our listeners.

Person-First Language

You would not introduce someone as your “cancer friend” because this person is not their illness; they are your friend. Their cancer is a condition in their life. When speaking of a person with any type of disability refer to the person, and then if necessary, speak of the disability (i.e., a person with mental illness, a person who has depression, Betty who is the mother of a son with bi-polar disorder).

Victimization

Just as actions can victimize people, words can victimize people.

Words such as “afflicted,” “suffers,” or “victim of,” reflect prejudicial attitudes which can lead to the assumption that all aspects of a person’s life are dominated by their illness or disability and that they are helpless and disempowered. Our language should always reflect our understanding that the illness is not the person; our language should not perpetuate stigmatizing attitudes.

Humor and Name Calling

Using, or tolerating others’ use of words that make fun of the condition of mental illness and persons who live with mental illness adds to the burden of stigmatization. This includes jokes and stories that mischaracterize mental illness.



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Church, Culture and Mental Health

Mental illness is unique among other illnesses in that the treatment usually is dependent upon some type of human relationship. Persons seeking treatment will need to speak with a therapist, spiritual leader, and doctor about personal matters. Effective treatment for mental illness goes beyond the need for medication; it also includes addressing psychological issues, social networks and matters of faith and spirituality. Therefore, it is important that attention be paid to language and cultural issues that may enhance or hinder treatment.

Mental illness is viewed differently in different cultures. Some cultures focus on the biology of illness; other cultures may believe that mental illness is the result of a lack of harmony with nature, separation from God, exposure to an evil spirit, punishment for past sins, etc. Knowledge of those beliefs will greatly improve the likelihood of effectively reaching out to those individuals who are from a different culture.

It is vital to understand how trust is expressed and evaluated in varying cultures. Trusting relationships are essential if individuals from minority groups are to accept support and assistance from systems such as churches, health care providers and mental health/substance abuse practitioners.

The United States is a multicultural, multiethnic, and multilingual society. This diversity impacts the way people relate to one another. Different cultures have different values, ways of perceiving the world, interacting with their environment and with one another, thinking and communicating. Some cultural differences are apparent, with observable behaviors, such as: distance between people when they are talking; whether or not there is direct eye contact; whether or not people touch each other; differences in communication patterns between men and women, children and adults; who shares meals and how; the concept of what it means to be on time; whether visits to friends are scheduled or are more spontaneous. Other differences are more subtle, such as: what is socially acceptable within a culture, what is valued and what is not, and what is funny and what is offensive.

In many traditional cultures, forming relationships is an especially important value. This process may involve many different means such as touching, sharing food, sharing gifts, talking about each other's religious

beliefs and values, or participation in other meaningful rituals. Trust is a key component of these relationships. It is vital to understand how trust is expressed and evaluated in various cultures. Trusting relationships are essential if individuals from minority groups are to accept support and assistance from systems such as churches, health care providers and mental health/substance abuse practitioners. Developing trusting relationships may make the difference between life and death for some individuals.

If we are to improve our understanding of one another, it is important not to make generalizations about groups of people. Focusing on superficial characteristics (skin color, accent, geography) without considering culture, hinders an empathetic, compassionate or caring response. Cultures have sets of norms and beliefs, including views on mental illness and its treatment. Faced with the task of helping an individual with mental illness from a different culture, it is imperative to find what is culturally appropriate. The stigma of mental illness is experienced in different degrees by different cultures. Some cultures attribute mental illness to evil spirits, while others recognize it as part of the human condition. Treatment varies from traditional healers to a strict medical model, or a combination of both. Access to individuals who fully understand a person's primary language is imperative, since there are some concepts that may be difficult to translate.



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CHAPTER TWO:
**CREATING SUPPORTIVE
FAITH COMMUNITIES**

*Message of His Holiness Pope Benedict XVI
for the 14th World Day of the Sick, 11 February 2006,
issued 8 December 2005*

The Church, particularly through the work of her chaplains, will not fail to offer you her help, well aware that she is called to express Christ's love and concern for those who suffer and for those who look after them.

I commend pastoral workers and voluntary associations and organizations to support in practical ways and through concrete initiatives, those families who have mentally ill people dependent upon them. I hope that the culture of acceptance and sharing will grow and spread to them, thanks also to suitable laws and health-care programs which provide sufficient resources for their practical application.

Welcoming and Valuing People with Mental Illness

Every parish has members who experience a serious mental illness or who have a close friend or family member who lives with the condition. With this reality in mind, parishes must thoughtfully consider how they can more fully welcome people



The most important thing I think I could pass on to a pastoral worker or somebody in a parish, is the need for a person to be accepted and loved, not in a phony way, not in a patronizing way, but to be genuinely accepted; not just to be given something to do within in the parish but to allow a person in, in such a way they know that they are respected, their dignity is known by the other person, and that they have something to offer.

– Fr. Bob Malloy, O.F.M., Cap.

affected by mental illness into the life of the community in a way that values their gifts and contributions to the church family.

Recognize

Recognizing that some people in the parish are affected by mental illness can help transform these usually “hidden” conditions into acknowledged realities in the lives of parishioners, just like physical health problems.

Consider

Considering with people with mental illnesses and their loved

ones how they experience Mass and other components of the life of the parish can lead to more meaningful participation. This process may reveal words or actions to be avoided because they stigmatize or exclude.

Facilitate Sense of Belonging

The formation of trusting relationships is basic to the experience of belonging. This can be accomplished in a number of ways: including the needs of persons with

mental illness and their families in the Prayers of the Faithful (name personally only with permission), providing needed accommodations (i.e., allowing for movement for some people unable to tolerate staying in one place during an entire liturgy or parish event), inviting people who might be shy or withdrawn to participate in liturgical ministries or other roles within the parish, accompanying a parishioner with mental illness to parish activities and introducing them to others.

Encourage

Encouraging all the members of the parish and its staff to ask questions and learn more about the effects of mental illness can increase the ability to respond in the most compassionate and pastorally appropriate manner.

Transform

When a parish becomes more welcoming of parishioners with mental illness and more appreciative of their gifts, it is evident that the power of God is at work transforming the community.



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Forming Relationships

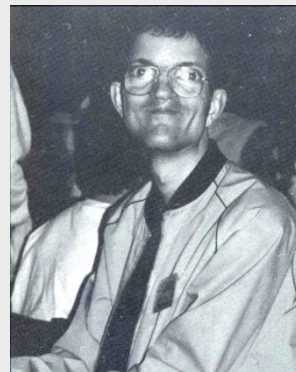
People with mental illness have many gifts and talents that add to the life of a community of faith. When forming a relationship with people with a mental illness, as with any person, we respect their dignity and know them by name. It is important to recognize in ourselves any preconceived negative images, fears, and prejudices we may have toward people with mental illnesses, often formed by distorted media images, isolated experiences, or the many myths surrounding mental illness. Once we strip away the generalizations and distortions we are better able to see people for who they truly are, individuals created in the image of God, our brothers and sisters.

People with mental illness should be known for their personhood, not defined by their diagnosis. One can miss coming to know the person in the fullness of their uniqueness and giftedness when focusing solely on illness and symptoms rather than on the person. As relationships develop and understanding of the illness increases, the very gifts of the person for others are revealed.

Each illness carries with it symptoms that may affect how people interact with others. The intensity and severity of the illness may impact one's ability to communicate. Mental illness can affect a person's ability to

My brother Bob developed mental illness as a young adult. At various times we heard it diagnosed as bi-polar or schizophrenia—it wasn't easily labeled. On top of this, his cognitive impairment was mild. He was very much included in our family. Bob moved freely through the neighborhood. He lacked true friends, as I think is the case for others who are in his situation—people who would call you up and say, do you want to do this with us, do you want to do that? He had the whole family, the extended family, people next door—that sort of thing. But to be accepted for who he is by a total outsider was not something that he ever really enjoyed. And that caused him an awful lot of frustration.

– Maureen O'Reilly



think sequentially, to manage emotions or mood swings, and to relate to others. Someone with depression may seem uninterested or distant. That is a symptom of the illness, not how the person typically relates to others. A person with schizophrenia may hear voices or experience hallucinations which are very real to them and is their reality. It is important not to deny that they are experiencing those symptoms and to help them understand that while you are not experiencing the same thing, you are willing to learn more about what they are going through. A person who has a panic disorder may be uncomfortable in church or at meetings so it is important to be sensitive to the person's need for space or need to get up and move around.

In mental health crisis situations, the individual with a mental illness may exhibit symptoms relative to the intensity of their illness and the treatment they are or are not receiving. A person exhibiting untreated symptoms of mental illness such as severe depression, schizophrenia, or bi-polar disorder may need crisis intervention by trained professionals. Therefore it is important to know the resources available in your area to get a person appropriate help. We should not engage the person in arguing or confrontation about the symptoms but rather comfort them and calmly help them to

Friendships which provide social and spiritual support within a faith community are a necessary component in a person's ability to manage their illness or recovery.

seek treatment. It is important at all times to act cautiously in order to ensure personal safety and that of the person to whom we are providing support.

Having a supportive relationship with a person with mental illness does not require the expertise of being a psychotherapist just as supporting a friend with cancer does not require being an oncologist. We are spiritual friends and companions who journey in faith with those whose lives are challenged and who are often isolated by their illness. Friendships which provide social and spiritual support within a faith community are a necessary component in a

person's ability to manage their illness or recovery. Understanding the symptoms of the particular mental illness of the person facilitates communication, supportive ministry, advocacy, and prayer with people with mental illness.

Listening is essential to forming trusting relationships. An individual's personal story is sacred. A person's story of suffering, and coping with a life-changing illness can reveal frightening and lonely experiences. Often a major mental illness is accompanied by doubts about God and can lead to a crisis of faith. Holy listening, that is, listening in the context of the healing presence of God, means hearing what a

person is sharing and letting their story unfold. A non-judgmental attitude that flows from an unconditional love for the person guides the response to their story. Holy listening allows and encourages people to relate their experiences in a supportive atmosphere that leads to comfort and healing. Holy listening brings one to a richer understanding of God's unconditional love for us through our acceptance of one another. Holy listening leads to a mutuality of understanding that allows the listener to begin to see that they are being ministered to as well. This supportive process leads to solidarity and mutuality in the relationship, enriching faith and hope. The listener then becomes the learner and both journey the path to wholeness and holiness.



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Building Supportive Peer Relationships

Receiving support and companionship from someone who is in a similar circumstance or facing similar challenges can be very helpful for many people. For people with mental illness and their families, support from peers can be particularly beneficial in reducing isolation and building community. Within peer relationships each individual has the opportunity to share his or her unique gifts and experiences with the other. Parish communities are particularly suited to be places of peer support.

Who Is a Peer?

- Another person with a mental illness;
- Someone who has a family member with a mental illness;
- People of similar age or background (including former classmates, neighbors, etc.);
- Anyone with whom a person has formed a supportive relationship.

How Might Peers Connect with One Another?

- Through introductions facilitated by friends, family members, parish staff or parishioners;
- By initiating conversations after Mass or during other gatherings at the parish;
- Through faith sharing groups with other parishioners interested in sharing a spiritual journey;
- By visiting people with mental illness who rarely leave their homes or are hospitalized.

What Might a Parish Do to Promote Peer Support?

- Acknowledge openly that some parishioners have mental illness and/or loved ones have mental illness and foster their involvement in the life of the parish;
- Invite and encourage people with mental illness to participate in parish functions where they can form relationships with peers;
- Sponsor activities to bring peers together, providing a safe place to meet and helping with transportation and other logistical details to enable peers to come together;
- Host workshops on peer support (e.g., The Way of Companionship with Craig Rennebohm or Peer-to-Peer training course sponsored by NAMI [National Alliance on Mental Illness]);

-
- Promote a trusting environment in which everyone can be comfortable sharing their experiences;
 - Emphasize the value of peers being compassionate listeners when people with mental illness choose to tell their stories;
 - Pray for those who are affected by mental illness in any way;
 - Recommend group support programs such as NAMI Family-to-Family, NAMI Peer-to-Peer, and CUSA.

Example

An urban parish designated one of its Lenten small faith sharing groups as being for people who live with mental illness themselves or who are close to someone with a mental illness. Informal personal invitations were extended to people likely to be interested in the group, and announcements in the parish's bulletin and in the bulletins of neighboring parishes helped promote the group. The parish provided a suitable space for the group to meet. The facilitators assisted with hospitality, reminder telephone calls and emails, and coordination of schedules to accommodate those using public transportation. A simple lunch provided by the facilitators contributed to community building through the sharing of each other's lives. Because of the relationships forged in the group, the members and facilitators committed themselves to continuing the group throughout the year.

Parish communities are particularly suited to be places of peer support.

As a result of the visibility of the group, the parish as a whole started becoming more aware of the presence of people with mental illness. Seeing the notices in the bulletin, several people with mental illness began attending Mass at the parish more regularly, viewing it as a more welcoming place to worship.



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Reaching Out to Families

As with any serious illness, when a family member is diagnosed with mental illness, every member of the family is affected. Whether the person with mental illness is a mother, child, spouse, or grandparent, everyone shares in their suffering. Depending on the role within the family of the person with mental illness, the individual and family members have unique support needs. For example, when a child is diagnosed with serious mental illness, the parents are desperate to find appropriate help, while siblings may feel frightened, left out, confused or embarrassed.

Feelings of confusion and fear are a common family experience. Before the person's diagnosis, family members are often trying to make sense of what is happening in their loved one's life. There is hope that perhaps everything will be back to normal and behaviors and bewildering talk might end. Perhaps the family member was brought to treatment only after a crisis occurred. It is quite natural for families to have many questions: Will my family member get better? Will they ever be able to return to their typical life? Why is this happening to our family?



Mental illness is really an illness that affects the whole family. We can't separate, oh, this person in my family has a mental illness and it has nothing to do with me. It really does. You still need to have a healthy life despite the illness, so make plans to have good family time. – *Lissette Mira-Amaya*

Helplessness, shame, anger, and grief are common feelings for families experiencing a diagnosis of mental illness. There can be major changes in personality, in the person's ability to function socially, or to cope in everyday situations. It may be difficult for a person to be relieved from troubling thoughts and feelings. For the family, it is troubling to see the person they know and love go through a dramatic change. The familiar person can become like a stranger, difficult to understand, displaying disturbing behavior.

One out of five families has a family member who lives with some degree of mental illness. In light of this statistic, a parish can appreciate how prevalent mental illness is in their parish family. Only slowly may families and parishes adjust adequately to the demands that mental illness makes on them. As families seek to know as much as possible about the illness, and learn how best to support their family member, so too does the parish family.

Accurate information about mental illness and discovering points of contact for nurturing a relationship with the individual and the family are at the heart of providing the kind of support that breaks through the feelings of isolation and loneliness that often accompany mental illness. In relationship, support needs are revealed. It is important to be sensitive to a family's needs depending on what stage in the unfolding of the illness they are experiencing. Initially, they may be uncomfortable disclosing the illness publically. These feelings should be acknowledged and respected.

Appreciating the stigma that often accompanies the diagnosis of mental illness, the parish family can give voice to this illness through general prayers of the faithful, awareness posters, presentations, and panel discussions. A diagnosis of mental illness needs the same outreach and support that you would provide for a diagnosis of cancer or other illnesses. Too often the kinds of help we offer parishioners facing physical illnesses are not extended to people and families with mental illness crises.

Accurate information about mental illness and discovering points of contact for nurturing a relationship with the individual and the family are at the heart of providing the kind of support that breaks through the feelings of isolation and loneliness that often accompany mental illness.

Specific actions from their parish that families have found helpful include:

- Informative and supportive training on mental illness within the parish;
- Bringing together families to create a faith-based support group;
- Advocating around justice issues related to public social services for people with mental illness;
- Offering to visit the family member if hospitalized or at home;
- Being aware of the impact mental illness has on siblings and learning from the family what might be some helpful ways to provide support;
- Acknowledging a person's absence with a positive message (e.g., "Tell Mike we missed him. How is he doing?");
- Staying engaged with the family as they go through this challenging time
- Providing meals, offers to shop, lawn mowing, etc.;
- Inviting the individual or family member out for a meal or coffee;
- Extending an invitation to parish activities;
- Offering to accompany the family through the maze of the mental health system;
- Being aware of community resources that might be supportive to the family (e.g., NAMI [National Alliance on Mental Illness] Family-to-Family training).



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Raising Awareness through Bulletin Articles

It is recommended that the following series be introduced with an article from the pastor asking the parish to be aware and involved at some level in outreach to persons with a mental illness and their families. After each article a contact person within the faith community should be identified for people who want further information.

Focus on Mental Illness (Week 1 of 7—Demographics)

According to the National Institute of Health, in a given year about one in four people has a diagnosable mental illness, while one in seventeen has a severe and persistent mental illness. One in five families is affected. Consider the prevalence of this illness in our own parish community, and the support needs of parishioners and their families. Future articles will address ways in which each of us can be of support.

Focus on Mental Illness (Week 2 of 7—Living with Mental Illness)

Mental illness is cyclical, where a person experiences periods of stability interrupted by times of instability. With effective treatment and support, many people with mental illness are able to lead relatively normal lives, and their illness may not be evident to others. For people in our communities who live with severe and persistent mental illness, it can be significantly debilitating. Mental illness impacts self esteem, relationships, and the ways in which an individual participates in school, work and the community. How can we be of support to people in our parish community living with this challenging illness?

Focus on Mental Illness (Week 3 of 7—Impact on the Family)

Many families are ill equipped to respond to the multiple challenges of a family member's diagnosis of mental illness. Behaviors can be misinterpreted, and finding effective resources and medical interventions may prove overwhelming. The strain on the family can be significant. The stigma that often accompanies this illness may cause families to be hesitant to share their need for support during this difficult time. How can our parish be of support to families with this need?

Focus on Mental Illness (Week 4 of 7—Language)

Language is important, as it communicates attitude. Person-first language is always preferred, as it reflects our respect of the dignity of each person. When referring to a person with mental illness, it is important to say "a person who has a mental illness" rather than category language, such as "the mentally ill." Consider how we speak about mental illness and how it is referred to by the media, and any changes that need to be made.

Focus on Mental Illness (Week 5 of 7—Stigma)

Feelings of isolation often accompany the experience of mental illness by people and their families. Isolation is often caused by social stigma: the misperception that mental illness is a question of character or a punishment from God. Language, jokes and misinformation perpetuate stigma. The stigma associated with mental illness can cause people to be hesitant to seek available services and treatment, and can be an obstacle to supportive relationships. In what ways can our parish address the behaviors that perpetuate stigma?

Focus on Mental Illness (Week 6 of 7—Justice Issues)

In 1963, when the de-institutionalization of mental institutions, asylums, and hospitals was mandated, the local communities that were to provide services never received the necessary and promised funding, resulting in hundreds of thousands of patients with no place to go. This dilemma still exists today: many families are ill equipped to handle the needs of family members with mental illness, and many small-scale institutions have precisely the same terrible conditions decried in 1963. Community based services are often underfunded, access to health care may be a continual challenge, and far too many people with mental illness are on their own—often homeless or in prison. What action steps can our parish take to advocate for better systems of care for people with mental illness and their families?

Focus on Mental Illness (Week 7 of 7—Taking Action)

As a healing community we can support people with mental illness and their families with unconditional love in a number of ways:

- Increasing our awareness of mental illness and its impact on the lives of individuals and their families;
- Identifying mental health resources and services in the community;
- Offering prayers for and support to individuals and families;
- Creating ministries of spiritual support;
- Serving on parish committees for outreach to individuals and families;
- Getting involved in peer-to-peer ministry; and advocating on mental health care and other justice issues.



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Moving from Understanding to Action



Well, one thing I do think is that people have to remember that there's people out in the world like myself that need help—they can get along without it, but they need it and they might not even realize they need it until they find there is help. And it's not going to cost you a lot of money, not going to cost a lot of your time, but to give that person a feeling that they're needed in this world and show them God, show them that other people care about them—that's very important. People don't realize how important that is to mentally ill people. – *Ruth Reskey*

The people of God are called to be communities of compassion, hope and justice for people with mental illness and their families. Parishes can respond in support of parishioners with mental illness through already established ministries in the life of the parish and by incorporating mental illness issues into the ministerial agenda. It is important to recognize that the illness is rarely talked about due to the lack of understanding about mental illness and the associated stigma. It is critical that all members of the parish recognize their own conscious or unconscious misconceptions and/or prejudices toward persons with mental illness and transform their perceptions through education and training on the facts. One does not have to become a mental health professional, but it is important to have accurate information about mental illness to effectively support and advocate for those living with this condition.

The more that parishes respond with love and acceptance, the more its members living with mental illness or those who have a family member with mental illness are likely to overcome their fears of rejection and feel a sense of belonging as an engaged member of the parish community.

Parishes can be instrumental partners in the supportive companionship and possible recovery of people with a mental illness by engaging in the following actions:

- Educate the parish community on mental illness through training which includes people and their families sharing their experience.
- When speaking about the illness use “person-first” language, i.e., “person with a mental illness” rather than “the mentally ill.”
- Identify community resources. Prepare and post a list of contact numbers to respond to routine and emergency mental health needs.
- Visit people with mental illness when they are unable to leave their homes or are hospitalized. Provide support with cards, bring the Eucharist, prepare meals.
- Organize peer support and family support groups within the parish.
- Include specific prayers for those affected by mental illness in the intercessory prayers at Mass. (Personalize only with the individual’s permission.)
- Incorporate mental illness in homilies. Include references to persons with mental illness and their concerns in homilies about social justice, caring for the poor, discrimination, and compassionate outreach to others. Avoid words or phrases that add to stigmatizing those who have mental illness.
- Include people with mental illness in opportunities for healing prayer and services (i.e., Sacrament of the Anointing of the Sick).
- Raise awareness of mental health issues through the church bulletin or newsletter.
- Offer the parish facilities and hospitality to host mental health support programs, e.g., NAMI (National Alliance on Mental Illness) Family-to-Family.
- Partner with mental health professionals, advocacy groups, and other churches for referrals, advocacy, and support groups.
- Encourage the parish peace and justice ministry to address systemic problems that affect people with mental illness.
- Encourage parishioners to consider utilizing their own businesses, housing, or work in the real estate industry to support the housing and employment needs of people with mental illness.
- Invite people with mental illness, family members, mental health professionals or advocacy groups to speak at meetings of parish organizations.
- Offer peer support. This is a ministry in which persons affected by a major mental illness and other parishioners can support each other.

It is important that persons with mental illness feel welcomed and supported within the parish. Nonjudgmental love and acceptance of the individual enables this

welcome and support. The more that parishes respond with love and acceptance, the more its members living with mental illness and their families are likely to overcome their fears of rejection and feel a sense of belonging as an engaged member of the parish community.



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Responding Compassionately To Difficult or Challenging Behaviors

Every faith community will have occasional experience of behaviors by parishioners or visitors that may be atypical for the community and may be perceived as annoying, distracting, or uncomfortable. These behaviors usually do not pose a threat or safety risk for the community but need to be responded to with compassion and respect for the person and in a manner consistent with the values of the community.

Parishes have described several such instances.

- In the middle of Mass, a man unknown to the community walks throughout the church collecting money in his hat.
- As he goes to unlock the church for morning Mass, it is not uncommon for the pastor to find someone sleeping on the front porch of the church.
- A key code is given to parishioners to use the prayer chapel. A woman who is homeless identifies herself as a member of the parish and wants the key code to use the chapel at night because it is safe. Other parishioners express concern that they don't feel comfortable if the woman is there.
- A couple who are parishioners regularly attend Mass and parish events. Other parishioners have indicated that it is difficult to sit next to or near the couple because of the unpleasant odor of their clothing and lack of personal hygiene.
- A parishioner with mental illness wears headphones to Mass and keeps them on throughout the Liturgy.
- A parishioner with mental illness is very agitated during Mass and frequently gets up from his seat to pace in the aisle.

These behaviors do not constitute a crisis but could indicate a need for education or accommodation. There is no generic "best" response to such situations. There are however, guidelines that can suggest a response that is pastoral and respectful of the person.

Relationship – Is this a person known by the community? Are there members of the community who know this person and have a relationship of trust with the individual? If this person is unknown and new to the community, who best in the community could establish rapport and communicate with the person?

Behavior – All behavior is communication. What is the behavior that is difficult and what need might the person be expressing through the behavior?

Incidents such as these help parishes clarify behaviors that are acceptable or tolerated or not acceptable in the parish. These may be unique to each parish.

Response – The first approach would be to address the situation most simply. Sometimes it is as simple as clarifying what is disruptive to the community and asking the person not to continue the behavior. If the behavior persists, it is helpful to discuss the situation with pastoral staff to develop a response plan. If the behavior escalates, pastoral staff needs to consult with mental health professionals to process the situation and learn appropriate ways to respond.

In the example of the person collecting money, a simple approach would be for an usher to ask the man to come aside to talk with him. Asking the person’s name, the usher can explain that during Mass people are praying. There is a collection during Mass taken by the ushers. The money is given to help pay the parish bills. If a person has financial need, the parish has a program to help people in need, (St. Vincent de Paul Society). It may be necessary to clearly name the behavior that needs to be discontinued—not in a punitive or demeaning way, but as a matter of clarifying the norm for behaviors during Mass. “Please do not collect money before Mass, during Mass, or after Mass. If you would like, after Mass I can introduce you to the Pastor or a member of the St. Vincent de Paul Society who might be able to help you.” Then invite the person to join the community in prayer for the rest of the Liturgy.

***There is no generic
“best” response to
such situations.***

The person may respond by staying for Mass and meeting the Pastor or the person may choose to leave. If the first approach is not effective, and the person continues the behavior, it may be necessary to clarify what was communicated to be sure the person understood. If the person persists in the behavior, the response escalates to asking the person to leave. Express to the person that they are welcome to come back, but may not collect money.

Accommodations – Because of some symptoms associated with certain forms of mental illness, people have developed ways of accommodating these symptoms so that they are less interfering with activity. These can include a person wearing headphones and listening to music to distract from “voices” the person is hearing or a person needing to pace to calm feelings of agitation, sometimes a side effect of certain medications. By understanding the illness and the person’s need, the parish can accommodate by allowing or providing for certain behaviors (headphones or pacing).

Resources – It is extremely helpful for parishes to identify helpful resources in the parish (mental health professionals, social workers, medical professionals, care providers, mental health peers, etc.) as well as local mental health resources and services within the community. It is most effective not only to identify the resources but learn how the system works, how a person would access those services. Some communities have agencies such as Project Respond which provide mental health professionals to help assess a challenging situation and offer options and resources. Parish staff and parishioners benefit from having mental health resource representatives come to explain their services and how to access those services.

Some basic assumptions underlie every response to these challenging or difficult situations, expressed both in word and action:

- Respect always for the dignity of the person;
- Always help and do no harm;
- Prevent stigma by remembering that these situations are the exception and not the rule;
- Realize that there are limits to what the parish can do;
- Foster a sense of mutuality of respect—for the person, for the community;
- Acknowledge the need for education and preparation;
- Appreciate the potential of the parish to always grow as a community of support and hope.

Above all, remember that developing relationships with people with mental illness in ordinary situations ensures that it is more likely that the community will be helpful to the person if ever there were to be a crisis—or help minimize the likelihood that there will even *be* a crisis.



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Organizing Support Ministries

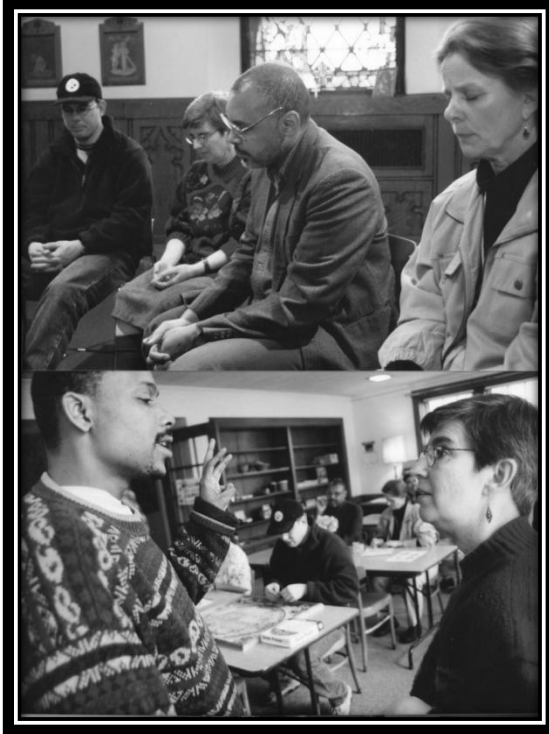
The Church has a unique role to play in supporting people with mental illness and their families. As the Body of Christ, we are called to witness the love of God for all people. Just as the Church provides meaningful support to other groups with specific needs, such as youth, widows, and those who are divorced or separated, so too those whose lives are affected by mental illness benefit from an experience of community where they can enjoy growth in faith in a way tailored to their particular needs. Such support is a sign and sacrament of God present and embracing. Addressing the need for support is so essential to sustaining a person and their families during the difficult times of this illness.

Once this need for support is understood, the parish may still feel at a loss as to how to begin. A good first step is to **assess the needs** as they are expressed by people with mental illness and their families. It might take a little effort, since oftentimes people with mental illness and their families are not visible: because of stigma they may be reluctant to be open about the situation, or because of the nature of the illness itself they may not be able to be present and active in the parish. The prevalence of mental illness (nearly 1 out of 4 people live with some diagnosed mental illness, and 1 in 17 with severe and persistent mental illness) supports the need for action in every parish. It is important not to forget the least served: those whose mental illness is most severe and persistent and who may present the greatest challenge. Often needs are revealed through discussions within parish awareness programs.

A second step is to **enlist the support** of a key person in the community. This could be a pastor, DRE, diocesan leader, or anyone whose support will facilitate the task and validate the Church's commitment. This person does not need to be actively involved, but offers guidance, support, and a communal voice to address the need.

A third step is to **consult with others** who are experienced in providing support for people with mental illness and their families. The NCPD website (www.ncpd.org) and the NCPD Council on Mental Illness can be helpful resources in your planning.

We are called to be that community where all—including and especially those whose lives are impacted by mental illness—can find Jesus in our midst.



Almost every parish has among its members professionals in the field of mental health (counselor, social worker, psychologist, etc.). It is important to enlist their support to be an on-call “guide” for program development, training, and guidance, and to field questions or process occasional problems.

A fourth step is to **plan a strategy** to provide support over an extended period of time. This may involve a variety of programs. Begin with what can most readily be accomplished, and then consider next steps. Several models that have been found to be effective in parishes include:

- Awareness presentation – NCPD workshop
- Prayer and devotional groups (weekly, monthly, quarterly) – St. Dymphna Society
- Sponsoring events – Mass for Mental Illness Awareness; prayer service or other observance of Mental Illness Awareness Week (first full week in October) or Mental Health Month (May), celebration of St. Dymphna’s feast (May 15)
- Family support groups – Craig Rennebohm
- Spirituality groups – Faith and Fellowship, Soup for the Soul, Faith and Recovery, Portland Archdiocese Faith Sharing
- The parish hosting established mental health support programs – NAMI (National Alliance on Mental Illness) Family-to-Family, NAMI Peer-to-Peer, NAMI In Our Own Voice, Emotions Anonymous, Recovery

(See Chapter Three for further information on these models.)

Important considerations in selecting the appropriate program include the following:

- What is the purpose—short-term and long-term goals?
- What are our available resources (personnel, volunteers, facilities)?
- What can be effectively accomplished with these resources?
- How will additional resources be obtained, if needed?
- What will be the program model?

-
- Who will be invited?
 - How will the invitation be extended?
 - Where will the program take place (church-related sites such as parish centers, diocesan offices, Catholic churches [*strongly encouraged*]?)
 - How will effectiveness be measured?

A fifth step is **implementation of the support plan**: recruit and train volunteers, secure a location, finalize dates with church calendar, publicize program/activity, prepare materials, create environment of hospitality, provide for



You don't always have to have answers, just being with people is important and being open to receive ministry and friendship from people has been a huge lesson. So for me the highlight was just getting to know Thelma and becoming friends with a person who had schizophrenia. I had all of the preconceived notions and the stigmas and all those kinds of things associated with mental illness...and just to come to know and become a friend—not just a minister *to*—but a friend *with*. – *Connie Rakitan*

disability access and accommodation needs.

As in any good project, *leadership* is key. It is important that the person(s) selected can work well with others, be able to listen as well as direct, and can effectively work within the parish and diocesan structure.

Hallmarks of successful support programs include:

- Understanding the unique needs of the people who are part of the community;
- Manageable size;
- Hospitality (greetings, refreshments, etc.);
- Predictability and order;
- Theology and spirituality consistent with Catholic teachings (see Chapter Three for Theological Framework);
- Enhance (instead of substituting for) parish inclusion;
- Spiritual focus;
- Timely communication with all involved;
- Ongoing support for volunteers/leadership.

Jesus assured us of his presence in the gathering of believers. This promise reminds us that in *community* we encounter God. We are called to be that

community, where all, including and especially those whose lives are impacted by mental illness, can find Jesus in our midst.



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Responding Pastorally to Crises

Crisis Planning

Prior to a crisis, it is recommended that a person with a mental illness prepare a crisis plan. Therefore if the person experiences a crisis, the following preferences will be identified:

- People to be contacted;
- People not to be contacted;
- Preferred hospital.

The plan is written out, signed by the person, and given to trusted friends and family members. – *Lisette Mira-Amaya*
– *Ruth Reskev*

Like people with any other health condition, people with mental illness can experience a wide range and intensity of symptoms, affecting them and their families to varying degrees. Like other people in a parish who are affected in some way by physical illnesses, people affected by mental illnesses often desire the support of the parish community, including the pastoral outreach of its ministers.

Definition of Crisis

A crisis can be defined as any situation in which the life or well-being of someone is in danger.

Crises that people with mental illness might experience include: a worsening of depression leading to contemplating or attempting suicide; the emergence of disorganized thinking leading to behaviors that could result in harm to themselves or to other people; or an adverse reaction to medication. Behavior that some people find merely annoying or distracting does not constitute a crisis, but might indicate a need for education or accommodation (e.g., suggesting parts of the church where someone who is restless can pace if necessary during Mass).

Preparing for a Crisis

Ideally the first step in responding to a crisis is anticipating crises and preparing for them. Preparing to respond to a crisis includes anticipating the types of situations that could occur and what actions might be helpful to the individual and his or her family.

Parish leaders, ushers, and other parishioners should know how to access emergency services. An up-to-date list of telephone numbers, such as the local crisis line, mental health service, NAMI (National Alliance on Mental Illness) chapter and emergency services (e.g., 911), should be posted near telephones. Parish staff could be trained by parishioners who are mental health professionals or by enlisting the

help of the local community mental health center. Scenarios could be role-played to help parish staff contemplate situations and responses.

In some locales, crisis plans are developed by individuals with mental illness and their support systems during a stable period. It is a guide for preferred actions in the event of acute illness. As the relationship forms between the parishioner with mental illness and the parish, the individual may wish to share a copy of the crisis plan with parish staff. Such a plan would be held in strict confidence, and shared only with staff members who may be called upon to implement the plan.

Responding to a Crisis

When responding to a person experiencing a mental health crisis, the primary goal is to ensure the immediate safety of the person and those around him or her. This

Preparing to respond to a crisis includes anticipating the types of situations that could occur and what actions might be helpful to the individual and his or her family.

may require summoning emergency medical services.

When interacting with someone in crisis, using short, simple statements and directions is much more helpful than giving complicated instructions or attempting to engage in a detailed discussion.

If a person experiences a crisis during Mass or at a parish event, it can be helpful for several support people to accompany the person

to a quieter area from which you and the person can readily exit if necessary for safety concerns, while awaiting the arrival of emergency responders.

Emergency responses will vary by community and could include police officers, firefighters, emergency medical technicians, or mental health mobile crisis responders. When placing the 911 call, it is helpful to specifically request mental health mobile crisis responders. Offering to stay with the person while emergency responders assess him/her can help reduce the discomfort and fear the person is likely experiencing.

Support after the Crisis

Once the initial crisis has been addressed, the person will have a period of recovery that can be quite brief or very protracted. During this time, the person and his or her family can benefit from continued support from the parish. They will have pastoral needs, not unlike those affected by serious physical illnesses. However, they might feel isolated and uncomfortable talking about their experiences with mental

illness. Respecting the confidentiality of the person with mental illness and honoring the privacy of the family, pastoral staff should endeavor to keep in contact with the person and the family, offering prayer and at times the sacraments.

Due to concerns about privacy, hospital staff generally cannot acknowledge if a particular person is in their hospital, making it difficult for pastoral staff and other parishioners to make contact with a person who has been hospitalized as a result of a mental health crisis. However, you may be able to request from the nurses' station the telephone number of the patient access phone. In some cases, you may even be able to go to the specific psychiatric unit and ask for the person by name. The person then has the option of allowing or declining the contact, but will know that someone from the parish has made an effort to talk with them.

In many instances, it may be helpful to provide a parish meeting to debrief the crisis for members of the parish. This gives an opportunity for people to express their concern, to assess the way the parish handled the situation, and to learn helpful ways of pastorally responding to future crises.

Returning to the Community

Once people have recovered from mental health crises, they and their families might need support returning to their previous involvement within the parish. They may welcome an opportunity to review what had happened and to suggest ways to respond in the future. Parishioners may need to be educated that people's mental illnesses often vary in intensity over time and that just because a person had one crisis, does not mean the person will have another. Nor does it necessarily mean that just because a crisis is over it will not recur. Details about a specific parishioner's experience should only be revealed with the person's explicit consent.



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Pastoral Perspectives on Suicide

Suicide has particularly impacted youth and the elderly. There are interventions—medications as well as therapy—that can assist people who are thinking of wanting to die. But more importantly, I think, is for people who are personally connected with individuals who are talking about wanting to die or making references to “life being better without me,” whether they be a classmate of a high school person or a senior friend or a family member, to take this information seriously. – *Dan Kill*

A rapid increase in suicide in our time is cause for alarm among pastoral workers and, of course, family members and other survivors of this tragedy. The depths of depression can rob a person of his or her desire to live. Deaths by suicide are a result of such severe depression that the person is no longer capable of making a rational and moral decision. Today the church takes a more compassionate stance on suicide than it had in the past, owing to the knowledge now available about what precipitates the act itself and the act’s tragic effect on survivors.

Acknowledging the gift of life we receive from God, and recognizing that we are obliged to accept life gratefully and preserve it, there are occasions when a person resorts to this path as an only escape from deep psychological pain (*Catechism of the Catholic Church*, 2280-2282).

The *Catechism of the Catholic Church* further states:

We should not despair of the eternal salvation of persons who have taken their own lives. By ways known to him alone, God can provide the opportunity for salutary repentance. The Church prays for persons who have taken their own lives (2283).

Good pastoral practice demands that the family members and other survivors of suicide be treated with the utmost compassion and care. It is helpful to refer to this death as “death by suicide,” rather than saying a person “committed suicide,” which infers a deliberate choice to end one’s life. The decision is more likely a choice to end the pain and anguish that a victim of suicide is suffering. If a person survives the attempt, great care and love can be offered by family, friends, and professionals to

assure the person that he/she is loved and can find help in coping with the issues that cause such a depth of pain.

Finally, a Catholic who has died by suicide is deserving of a Catholic funeral and burial in consecrated ground, and Church law stipulates that this is to be provided.



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Advocating for Justice

As parish communities become more welcoming and understanding of the life realities of persons with mental illness, they need to recognize the importance of advocating in partnership with persons with mental illness on issues directly affecting their lives. People who live with mental illness are disproportionately impacted by the social injustices of prejudice, poverty, inadequate housing, unemployment or underemployment, lack of access to health care (especially mental health care) and inequalities within the criminal justice system.

Advocacy efforts require action at all levels: parish, local, state and national government. The following issues merit particular attention.

Health Care – The mental health care system in the United States is often described as dysfunctional and uneven in its care for people with mental illness. Mental illness is a treatable brain disease with better success rates than many other diseases. Studies have shown that proper diagnosis, medication, and an appropriate range of community psycho-social rehabilitation support services will deliver cost-effective results that are actually less expensive than the current disconnected delivery system now in place.

- Work for comprehensive health care reform. While effective treatments exist for most common mental illnesses, studies have shown that many individuals with mental illness do not receive referrals for these services in primary care settings.
- Recent health care parity legislation seeks to ensure more adequate benefits for mental health care. It is important to be informed about this legislation and to monitor that it is being implemented on behalf of people with mental illness.

Employment – Employment is key not only to economic stability, but to a person's well being—a sense of purpose, self esteem, and ability to contribute to society. Some individuals whose mental illness is managed may need some flexibility in the work environment to accommodate a possible episode due to the cyclical nature of the illness. Those with more serious, persistent mental illness may need supportive employment opportunities.

- Some people with mental illness face hiring and promotion discrimination because of their illness.
- Labor statistics indicate a 25% salary disparity between working-age people with disabilities compared to those without disabilities.

-
- The high incidence of unemployment throughout the country puts at greater risk those who live with mental illness and are seeking employment in a challenging job market.

Housing – Catholic Social Teaching has long recognized housing as a basic human right. However, for persons with disabilities this right is being seriously jeopardized by the crisis that worsens as housing costs continue to spiral upward.

- Affordable housing for people with mental illness is a major issue. If a person is unable to work, obtain a job with a decent wage, and/or is on disability financial assistance, housing options are very limited.
- Deinstitutionalization of public psychiatric hospitals created an increase in homelessness because of poorly funded community mental health programs and support services. Advocacy for comprehensive services and affordable housing in the community is necessary to address the issue of homelessness for people with mental illness.

Criminal Justice – Lack of adequate mental health care services has often led to the unnecessary and inappropriate incarceration of people with mental illness for minor crimes. In addition, the unjust system of death penalty sentencing of people with serious mental illness has long been an advocacy issue.

- There is need for adequate and properly trained legal representation. All too often, attorneys are ill prepared about mental illness, and therefore fail to provide a proper defense for their clients.
- Within the jail and prison systems there is need for adequate mental health services, both for assessment and treatment, including access to appropriate medications.
- Advocacy is needed to ensure that the death penalty is not a sentencing option for a person with mental illness. In the cases of prisoners with mental illness serving on death row, actions can be taken to request a commutation of the sentence to life in prison.

Guided by the Catholic Church’s rich teaching on social justice—affirming the innate dignity of each person, calling everyone to community and solidarity, and stressing the preferential option for the poor—parishes can be leaders in the community as concerned and active citizens, employers and business people, advocating for just social policies that protect the rights of all people, especially those who are most vulnerable in society.



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Homily Preparations

Homilies are powerful opportunities to transform perceptions of the reality of mental illness by revealing or communicating the impact on the individual or their family. Good homilists are always aware of the people they are addressing and their needs in light of the sacred scriptures of the given day. It is important to remember that some of the people addressed in a Sunday homily may either have a mental illness or be in close relationship with someone who does. Approximately one in four people have a diagnosable mental illness in a given year, and one in seventeen live with a persistent and severe condition. And, one family in five is impacted by the mental illness of a loved one.

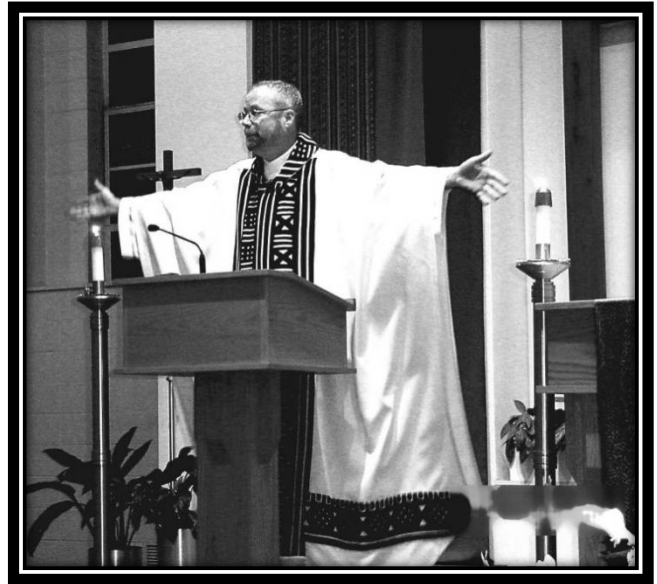
Several considerations are important in homily preparation when addressing issues related to mental illness.

First, as outlined in Section One, *Understanding the Reality: The Power of Language*, language should be carefully chosen because it can either reflect a respect for the dignity of the person or alienate and perpetuate negative stereotypes.

Second is the application and interpretation of certain scripture passages which may be problematic for people with mental illness because in some real circumstances they have been interpreted literally and acted upon. Thus it is helpful to know that people in the congregation may be hearing things in ways that homilists don't intend or expect. Some examples of such scripture:

Jesus advising his listeners to pluck out their offending eye and cut off their offending hand rather than fall into sin.

Another example is the scripture of Abraham taking his son Isaac to be sacrificed, which can be heard by a parent with a mental illness as confirmation of voices heard internally with which he or she may actually be struggling.



The scripture call to abandon everything and follow the Lord is also subject to literal interpretation.

Homilists need to be aware of how they speak about these scriptures and to take reasonable precautions with their interpretations. When referring to these scriptures, or others like them, it is very important to make a clear point of what the Gospels are promoting, especially in the face of words that can lead to unfortunate consequences. To presume that the hearers know better than to pluck out an eye, for example, may not be wise. It may also be advisable, in rare instances, to substitute one reading for another if the homilist is aware of potential trouble due to circumstances surrounding the people being addressed.

Language should be carefully chosen because it can either reflect a respect for the dignity of the person or alienate and perpetuate negative stereotypes.


Third, discussion of demon possession can be equally problematic. It is important to use discretion when relating the stories of Jesus casting out demons. In most cases, challenging behavior is not explained by demon possession, but rather is understood as resulting from biological or psychological conditions. The important point to consider and raise is the concern of Jesus for each person, and his desire to relieve them of their suffering.


As always, good pastoral judgment calls for a common sense approach to presenting the Word of God to hearers who have a variety of needs and burdens. The more homilists know their congregation, the better equipped they will be to help the people who are thirsting for the word of God. A worthy prayer before preparing a homily is to ask the Holy Spirit to guide the homilist in saying what the people really need to hear, in a way that they can hear the Word clearly and as it was meant to be understood.





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Prayers of the Faithful


-  For persons with a mental illness, and their families to find effective treatment for their illness and understanding and acceptance from others, we pray to the Lord.


-  For families who strive to understand and help their loved ones with mental illness, we pray to the Lord.


-  For people who live on the streets without homes or hope, we pray to the Lord.

-  For people with mental illness who are confined in jails and prisons, we pray to the Lord.

-  In thanksgiving for the compassion and dedication of mental health professionals and those providing care, we pray to the Lord.

-  For our elected officials to come to an understanding of the need for increased funding for mental health care, we pray to the Lord.

-  That the darkness of stigma, labels, exclusion and marginalization might be dispelled by the light of greater understanding, acceptance and respect for the dignity of every person, we pray to the Lord.

-  For each of us to reach out with support as we form a caring community, we pray to the Lord.



Sacrament of Reconciliation

The Sacrament of Reconciliation can be a healing experience for a person troubled with mental illness. First and foremost, the confessor extends a compassionate and understanding welcome to the penitent. It is important that the penitent feel comfortable and secure in this setting. Once trust is established and depending on how well he knows the penitent, the priest can assess the situation. Once the penitent shows genuine trust in the priest, great strides can be made. This may take some time, depending on the history of the person and any trauma from the past.

It will be helpful for the priest to give the person the opportunity to express what is most pressing on his/her heart. If this is matter for the sacrament, then, the priest can address this point with care to assure the person of his/her value and the forgiveness that God offers. If the person suffers with obsessive compulsive disorder, often manifested in scrupulosity (an oversensitive concern about one's own moral integrity), good pastoral practice emphasizes clarity and firmness along with compassion.

Ritual is important. The penitent may insist on a certain ritual of his/her own, for example, kneeling on the floor, reading a list of items from a paper or reciting certain prayers that are important to him/her. The priest should incorporate this into the rite of the sacrament as much as possible and give the penitent time to complete the ritual. If certain rituals are inappropriate, once the confessor has gained trust, he can gently begin to guide the penitent to other more appropriate ritual experiences. If the penitent requires more time to discuss the matter, or desires some spiritual direction, the priest can invite him/her to meet at another time or refer him/her to another person. It is important to know when to refer the penitent to a mental health professional for further assistance. The priest can gauge this by the behavior and anxiety level of the penitent. For example, if the person is obviously finding it difficult to stay focused on the matter at hand and can't seem to respond appropriately to the rite of the sacrament, the priest might ask: "Have you spoken to your doctor about what you are experiencing?" or "Have you talked with a counselor or therapist about this? Would you like the name of someone who can help you?"



Consistency is important. It helps to establish the practice of a person confessing to one priest for continuity in spiritual growth.



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Prayers and Reflections

Faith Reflections

An Inclusive Church Is Like a Stained Glass Window

Each Day...

When Even the Devil Deserts You

Commemorating the Bishops' Proclamation

Prayer for Inclusion

We Are One Flock

Merton Prayer

Faith Reflections

I think my faith is the only thing that pulls me through the struggles that I've had. I pray every day, read the Bible every day, say the rosary every day and if I didn't, I don't think I could get through the day. God is my Divine Healer. I think without God I couldn't have done it.

– Margaret Juricek



The night before Easter, I believe it was, that I became a member, I was baptized because I've never been baptized, and I was confirmed, and something happened. I just knew I belonged somewhere when that was all happening.

– Ruth Reskey

My daughter's mental illness has had a profound effect on my faith. It has taught me more than I would say anything I learned in theology and the books. One day we got a call from the nurses there and said that she had been overdosed on her medication and they had somehow mixed that all up and she had gotten too many medications. So they said she is out of it, she doesn't really understand what's going on around her, so they said don't come and visit her. Well, we immediately jumped in the car and went down to see her and assess the situation and it was not good. She had been overdosed and she was not able to recognize us, just very barely, so my wife tended to her needs. As we were kind of walking out the door actually, she turned and she looked at me and she said, "Dad when you come back would you bring bread?" I looked at my wife and I said what could she possibly want with bread, and I was a little frustrated after this long day and this terrible situation, so I said what could she possibly want with bread, and she looked at me and she said, "Church Bread." Well she wanted me to bring her the Eucharist. And right there, in that terrible moment, we knew Christ was present and so it was a very powerful moment that we knew even in the worst moment of our lives, God is with us.



– Deacon Tom Lambert

My faith? What does it mean to me? It means that I have hope. That I haven't given up, and that's about all you can have. It keeps you going, it's like, when all else is failed, it's like, God won't give up on you.
– *Rory Price*



My faith is what gets me through every day, what enables me to not always have the cynical or whatever attitude. But you know, you try to see your faith as a source of your joy, a source of your compassion.
– *Sr. Joan Baustian, OP*

My faith is my priority in life, my Catholic faith is, because I believe that I can live with this illness, I might get sick again but I'm learning new coping skills and my faith can help me do anything I want to do.

– *Coletti Ali*



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An Inclusive Church Is Like A Stained Glass Window

By Deacon Tom Lambert

When we see a stained glass window in a church, we are struck by the beauty of the story it tells. The window usually depicts a story from scripture or an aspect of our faith. Taken as a whole, the window gives a complete picture of a particular story or inspiring moment. When we approach the window and look closely at the art, we see that the window is made up of many pieces of glass. The pieces have different shapes and sizes, some are large and some are tiny. We see that the pieces are made of different colors. Upon closer inspection, we see that the pieces have flaws in them, some have lines or cracks, others have tiny air bubbles in the glass. But taken together as a whole, the unique pieces, big and small, of various colors, with all their flaws transcend their individuality and come together at the hand of the artist to give a dynamic story of faith. But what happens if part of the window is missing? What if we were to remove all the purple pieces of glass, or remove the large pieces, or the ones with bubbles in them? The picture would be incomplete. We would not get the whole story.

The body of Christ, the faith community, in one sense, is like a stained glass window. It lives the story of redemption and salvation in the reality of everyday life. The pieces of the story are made up of many kinds and sorts of people—young people, elderly people, married people and single people, people of color, people of different shapes and sizes, people who are divorced, people with various disabilities, etc.... Like the stained glass window, the body of Christ is made up of many parts. If we intentionally or unintentionally exclude, discriminate against or ignore one or more of the parts, we do not get the whole picture. We are missing the full story. The picture is incomplete.

For people with mental illnesses the societal stigma and misperceptions of the disease often keep them from participating in our parishes. The stigma and misperception by society are felt within their own community of faith. Parishes, rather than mirroring the cultural biases of society, should be challenging those assumptions and accepting and reaching out to all people—to open doors and minds to the gifts of all God's people. In places where there are barriers, either physical or attitudinal, the image of God's kingdom is far less clear and the story is incomplete. Parishes that truly welcome and include everyone in a proactive way portray the story of redemption and salvation as a clear and beautiful image of God's people.



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Each Day . . .

- I will recall that I am a child of God. I am one who is created out of Love. I am chosen, good, holy and have purpose...a task to perform here on earth before I return to the Father. I deserve to be treated as a person who has value and dignity.
- I will embrace my illness or my family member's illness as a friend this day looking for what it is teaching me about the mystery of God and life.
- I will not allow the stigma of mental illness to defeat me this day. I will choose to have power over stigma by detaching myself from the stigma.
- I will talk to someone today who will encourage me to see my goodness and holiness as a child of God. Maybe we will share a prayer together for one another.
- I will look for humor and reasons to laugh and be happy. Quiet joy will be my goal.
- I will read a passage from Scripture or something from a book of devotion, inspiration or spiritual reading that will encourage me to trust and hope in the power and love of God.
- I will seek twenty minutes of solitude, silence, prayer this day. If my mind won't quiet down, if my thoughts keep racing, I will offer that as my prayer to God. If necessary and helpful, I will listen to soothing instrumental music or inspirational/religious music to quiet me and remind me that God is present.
- I will walk outdoors marveling at a sunrise, a sunset, the song of a bird, the soothing colors of nature...the serenity of green grass, a blue sky, the softness of the pastel-colored blossoms of Springtime and the peaceful waters of a river, lake or stream that ripple and flow. I will remind myself that everything in nature is a reflection of the Creator and pleases the Creator just as it is, and so do I just as I am.
- I will delight in the knowledge that we are each created different because it is in our differences we make a more powerful and beautiful whole. We each reflect a different aspect of the mystery of life and God. Individually and together we are a Masterpiece!

-
- In God is my hope and my joy. I will give honor, glory and praise to God knowing and trusting what God has in store for me. We do not seek or like suffering but our suffering can make us strong in many ways and more compassionate and loving to others...our brothers and sisters in the Lord.

Knowing for sure that although I long for God, God's longing for me is even greater, I will rest in that knowledge this day.

*Reflection offered during a workshop on spirituality for people with mental illness
by Rita Sebastian Lambert.*



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When Even The Devil Deserts You

by ed cooper

I have a thousand faces,
And I am found in all races.
Sometimes rich,
Sometimes poor,
Sometimes young,
Sometimes old.
I am a person with the disabling pain,
of a broken brain.
You have names for my pain,
like schizophrenia, bipolar disorder, and major depression.
Some of you refer to me as crazy or insane.
The real fact is most of you don't refer to me at all.
You want me locked away out of sight,
But my only crime is my shattered mind.
I understand why you don't want to look into a darkened soul,
Because I cry when I am forced to make the journey.
Do you know the hurt I feel,
When I look into my family's faces and see their fear?
Fear of me and what I have become.
I try to tell them I will not hurt them
And to explain it is not their fault.
I try to reach out to them to ease their sorrow,
But I fail to be a comfort,
Because I cannot hide the agony of my soul.
I fight the demons of depression and despair.
I search for a solace for my soul.
I want my mind mended,
But you must understand that a broken brain,
Is more than mere mechanical failure.
It has many causes I am told.
It may be hereditary,
Biological, or environmental.
I don't know for sure what causes it,
But I know what it causes.
It causes the total destruction of your inner self.
It fragments you.
It makes you seek an end even if that means death.

You seek the end because you see not only what it has done to you,
But what it is doing to the ones you love.
The fear of death fades,
Because to a large degree you already feel dead.
You are not able to interact with others,
Nor are people willing to interact with you as they once did.
In fact,
It feels like you have fallen so low
Even the devil has deserted you.
I ask you,
Where do you turn When Even the Devil Deserts You?
To therapy?
It helps but only touches part of me.
To medications?
They too help but only partly.
Is there a path to a place that will touch all of me,
And not just mend my broken brain,
But touch the untouchable.
I once heard of such a path.
It was written about,
But my mind wanders so much I find it hard to read.
It has been spoken of,
But I hear so many voices I don't know which to follow.
If you know the path,
Would you please find me?
I may be in a hospital.
I may be on the streets.
I may be at home.
Please find me and take me into your arms.
Hold me there until we find the path,
That leads into the arms of the One,
Not afraid to touch the untouchable.
Please find my family too,
For their pain is as great as mine.
I may not be able to understand the written word,
Or even the words spoken to me.
I may not seem to know where I am,
But I will know the warmth I feel,
When you gently put your arms around me.
I will once again know I am loved.
(Printed with permission of Ed Cooper)

Commemorating the Bishops' Proclamation

Loving God,

You make each living person in your image,
Your gift of love and commitment to the human race.
A seed to build a community of interdependence and respect for all life.

As we celebrate the U.S. bishops' proclamation of welcome and inclusion,
open our hearts to their words.
Commit us to their proclamation that "There can be no separate Church for people
with disabilities. We are one flock."

Guide our hands to build access and welcome.
Guide our minds to understand the power and wisdom of human vulnerability.
Guide our actions to create parish communities open to the gifts of each individual.
Give us courage to stand up to the forces willing to destroy life because they fear
disability or make judgments about its "quality."
Give us understanding that your body is incomplete if people are left behind.
Give us an appreciation of the role we must play in spreading your Good News to all
we meet.

We praise you, Lord, for all of your good gifts.
We thank you for those pioneers who have worked tirelessly
to carry out the bishops' prophetic vision of 1978.

We give thanks for loving parents who welcome and nurture their children.
We appreciate all those living with disabilities who contribute their time and talents
even in the face of obstacles or rejection.

Guide us always, Lord, in your way.
Amen.



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Prayer for Inclusion

Creator God, we are your people. We look to the future with optimism and with faith in you, as we pursue our call to provide justice and fullness of life for all people with disabilities.

We pray that every man, woman and child may develop their potential and meet you in themselves and in one another.

May we enjoy a totally welcoming community, with you as our center, joined hand in hand with our sisters and brothers. We ask this in Jesus' name. Amen.

Based on the Pastoral Statement of U.S. Catholic Bishops on People with Disabilities.



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We Are One Flock

God, bless those who open doors
With faith,
With love,
With knowledge,
Assuring that
All your people may
Worship here.

God, bless those who
Welcome all your people
To the celebrations and
Obligations,
Membership within your
Church.

God, bless those who feel excluded.
Give them faith,
Give them love,
Give them the knowledge
Of your welcome.

Open our hearts
To move swiftly
Within your grace,
To hear your message
In silent words,
To glimpse your glory
beyond our sight,
To find your wisdom
in simple truths,
To accept our weakness
In your strength.

Let us join Christ
in breaking down those walls
Which separate us, one from another.



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Merton Prayer

My Lord God, I have no idea where I am going. I do not see the road ahead of me. I cannot know for certain where it will end. Nor do I really know myself, and the fact that I think I am following your will does not mean that I am actually doing so.

But I believe that the desire to please you does in fact please you. And I hope I have that desire in all that I am doing. I hope that I will never do anything apart from that desire. And I know that if I do this you will lead me by the right road though I may know nothing about it.

Therefore will I trust you always though I may seem to be lost and in the shadow of death. I will not fear, for you are ever with me, and you will never leave me to face my perils alone.

- *Thomas Merton*

*Permission for use of the prayer granted by
The Merton Legacy Trust.*

Patron Saint of People with Mental Illness: St. Dymphna of Gheel

Many people know St. Dymphna of Gheel as the patron saint of people living with mental illness. Few seem to know her background or why she is named such.

There are various legends surrounding the story of Dymphna, but the core narrative is this: She was the daughter of a pagan chieftain in Ireland in the 7th century. Her mother, who had been a Christian and had baptized Dymphna, died when her daughter was 14. Her father was devastated and had a long period of protracted grief. After a fruitless search for a second wife, his attention fell on Dymphna. Her resemblance to his beloved dead wife, coupled with his emotional and mental struggle after his wife's death, drove him to entreat her to marry him herself. Horrified, Dymphna fled with her confessor, an elderly priest by the name of Gerebran, to the city of Gheel in Belgium.

Unfortunately, her father pursued her and found her. His men murdered Gerebran and then, when Dymphna refused to go with her father, he beheaded her.

Dymphna's refusal to participate in this incestuous relationship led to her martyrdom. She has been named patroness of people with mental and emotional difficulties—not only because of the toll that her father's mental illness took on her family but because of her own emotional and mental anguish.

Dymphna was buried in Gheel. When her body was discovered in the 13th century, cures and miracles were being attributed to her, especially for people with epilepsy and people with mental illness.

But the most outstanding miracle is one that began centuries ago and still continues to this day. In the 13th century, an institution was built in Gheel where people with mental illness are admitted for a short time. Following the initial treatment, they are then placed with families in the village with whom they live and work side by side. They benefit greatly in this shared life with the villagers. The villagers see them as a part of their lives and have for centuries.

All of this is attributed to a simple young woman who lost her life in defense of doing the right thing. St. Dymphna is a legend and a model and has left a legacy for care and treatment of people with mental illness that defies the "wisdom" and sophistication of our own time.

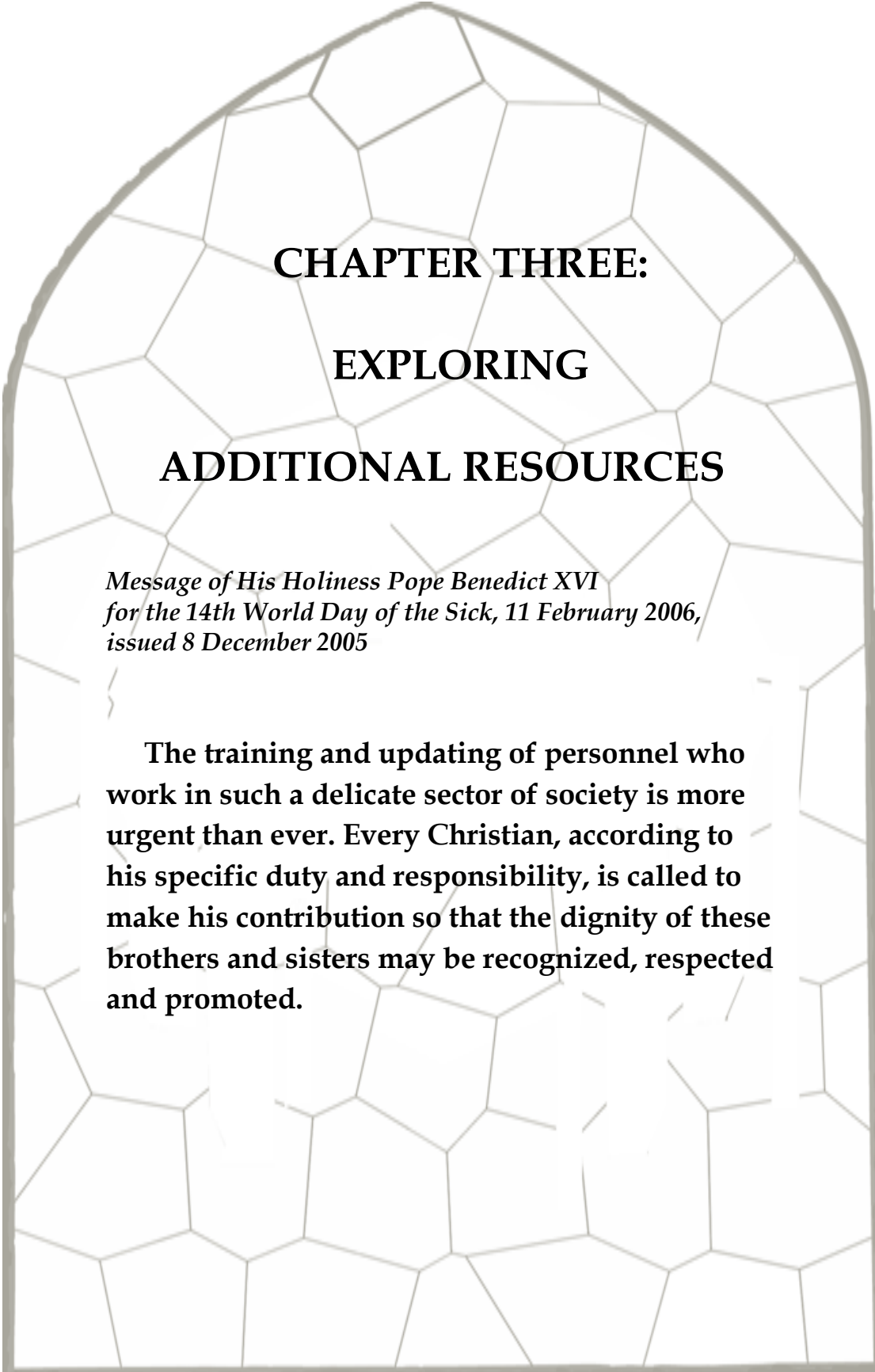


Prayer: Wise and diligent St. Dymphna, you found yourself in peril in your young life having suffered the death of your dear mother and the wrath of your father. Orphaned and in flight you took shelter in the wings of your heavenly Father.

Under your protection and care, many people with mental illness have been consoled and nurtured toward better health and healing. Look kindly on the needs of all who struggle today with mental and emotional problems. Be their source of strength and hope. Help them to know and understand that nothing can separate them from the love of God that comes through Jesus Christ, our Lord and Savior. Amen.



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CHAPTER THREE:
EXPLORING
ADDITIONAL RESOURCES

*Message of His Holiness Pope Benedict XVI
for the 14th World Day of the Sick, 11 February 2006,
issued 8 December 2005*

The training and updating of personnel who work in such a delicate sector of society is more urgent than ever. Every Christian, according to his specific duty and responsibility, is called to make his contribution so that the dignity of these brothers and sisters may be recognized, respected and promoted.

Church Statements

Theological Framework on Mental Illness

Pope Benedict's 14th World Day of the Sick Message, 2006

Pastoral Statement of U.S. Catholic Bishops on Persons with Disabilities

Order from <http://www.usccbpublishing.org/>

Guidelines for the Celebration of the Sacraments with Persons with Disabilities

Order from <http://www.usccbpublishing.org/>

Nebraska Bishops' Statement on Behavioral Health: Affirming the Dignity of the Mentally Ill

Theological Framework on Mental Illness

The National Catholic Partnership on Disability sets forth the following framework as a guide to the Church's ministry for and with people with mental illness:

Human Life Is Sacred. Every Person Is Created in God's Image.

"One of the fundamental truths of Christian belief is that each human being is created in the image and likeness of God (Genesis 1:26-27). The Catholic Church unconditionally embraces and faithfully proclaims this truth. It is the foundation for human dignity. Our commitment to this truth is measured through actions on behalf of the vulnerable and alienated in society, especially the poor and suffering." *Affirming the Dignity of the Mentally Ill, Nebraska Bishops' Conference, January 2005*

Since All People Are Created in the Image of God, Their Dignity and Worth Cannot Be Diminished by Any Condition including Mental Illness.

"Whoever suffers from mental illness 'always' bears God's image and likeness in themselves, as does every human being. In addition, they 'always' have the inalienable right not only to be considered as an image of God and therefore as a person, but also to be treated as such." *Pope John Paul II, International Conference for Health Care Workers, on Illnesses of the Human Mind, November 30, 1996*

Suffering Is Redemptive When United To Christ.

"Those who share in the sufferings of Christ are also called, through their own sufferings, to share in (eschatological) glory." *Salvifices Doloris, p22, Apostolic Letter from Pope John Paul II, July 15, 1999*

We Are the Body of Christ.

"The great strength of community is the uniqueness and giftedness of each member. The more each person uses their gifts, the stronger the community and the richer the relationships in that community. People are liberated if and when they use their gifts. People are imprisoned when they are prohibited or not enabled to use their gifts. Parishes are communities with great potential to receive and nurture the giftedness of people with disability. The Christian community is one in which all people can claim an equal place and contribute through presence and action." *A Pastoral Document for Parishes, Bishops' Committee for the Family and for Life, Australian Catholic Bishops Conference, 2004*

"It is everyone's duty to make an active response; our actions must show that mental illness does not create insurmountable distances, nor prevent relations of true Christian charity with those who are its victims. Indeed it should inspire a particularly

attentive attitude..." *Pope John Paul II, International Conference for Health Care Workers, on Illnesses of the Human Mind, February 11, 1984*

The Word of God Affirms the Dignity of All People. Interpretation of Scripture Should Be Consistent with the Current Understanding of Mental Illness.

"...To interpret sacred scripture correctly, the reader must be attentive to what the human authors truly wanted to affirm and what God wanted to reveal to us by their words. In order to discover the sacred author's intention, the reader must take into account the conditions of their time and culture, the literary genres in use at that time, and the modes of feeling, speaking, and narrating then current..." *Catechism of the Catholic Church #109, 110*



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Message of His Holiness Benedict XVI For the 14th World Day of the Sick

Dear Brothers and Sisters,

The 14th World Day of the Sick will be celebrated on 11 February 2006, the liturgical Memorial of Our Lady of Lourdes. Last year the Day was celebrated at the Marian Shrine of Mvolyé, Yaoundé, and on that occasion the faithful and their Pastors, on behalf of the whole African Continent, reaffirmed their pastoral commitment to the sick.

The next World Day of the Sick will be celebrated in Adelaide, Australia, and the events will culminate with a Eucharistic Celebration in the Cathedral dedicated to St. Francis Xavier, an unflagging missionary to the peoples of the Orient.

On this occasion, the Church intends to bow down over those who suffer with special concern, calling the attention of public opinion to the problems connected with mental disturbance that now afflicts one-fifth of humanity and is a real social-health care emergency.

Recalling the attention that my venerable Predecessor John Paul II devoted to this annual event, I too, dear brothers and sisters, would like to be spiritually present on the World Day of the Sick, to pause in order to reflect, in harmony with those taking part, on the situation of the mentally ill in the world and to call for the commitment of Ecclesial Communities to bear witness to the tender mercy of God towards them.

In many countries, legislation in this field does not yet exist and in others, there is no definite mental-health policy. It should then be noted that prolonged armed conflicts in various regions of the world, the succession of terrible natural catastrophes and the spread of terrorism, in addition to causing a shocking number of deaths, has triggered psychological traumas that are sometimes difficult to cure in many survivors.

In the economically highly-developed countries, experts then recognize that at the origin of new forms of mental disease we may also find the negative impact of the crisis of moral values. This increases the feeling of loneliness, undermining and even breaking up traditional forms of social cohesion, starting with the family institution, and marginalizing the sick, particularly the mentally ill who are all too often considered as a burden on the family and community.

Here I would like to praise those who in different ways and capacities work so that the spirit of solidarity is not lacking and that people persevere in taking care of these brothers and sisters of ours, finding inspiration in human and Gospel-based ideals and principles.

I therefore encourage the efforts of those who strive to ensure that all mentally ill people are given access to necessary forms of care and treatment. Unfortunately, in many parts of the world, services for these sick people are lacking, inadequate or in a state of decay.

The social context does not always accept the mentally ill with their limitations, and this is another reason difficulties are encountered in securing the human and financial resources that are needed.

One perceives the need to better integrate the two approaches: appropriate therapy and new sensitivity towards disturbance, so as to enable workers in the sector to deal more effectively with these sick people and their families, who would be unable on their own to care adequately for their relatives in difficulty. The next World Day of the Sick is a suitable occasion to express solidarity to families who have mentally ill persons dependent upon them.

I would now like to address you, dear brothers and sisters, tried by illness, to invite you to offer your condition of suffering, together with Christ, to the Father, certain that every trial accepted with resignation is meritorious and draws divine goodness upon the whole of humanity.

I express appreciation to those who help and care for you in residential centres, day hospitals and wards providing diagnosis and treatment, and I exhort them to strive to ensure that medical, social and pastoral assistance for those in need is never lacking, respectful of the dignity proper to every human being.

The Church, particularly through the work of her chaplains, will not fail to offer you her help, well aware that she is called to express Christ's love and concern for those who suffer and for those who look after them.

I commend pastoral workers and voluntary associations and organizations to support in practical ways and through concrete initiatives, those families who have mentally ill people dependent upon them. I hope that the culture of acceptance and sharing will grow and spread to them, thanks also to suitable laws and health-care programs which provide sufficient resources for their practical application.

The training and updating of personnel who work in such a delicate sector of society is more urgent than ever. Every Christian, according to his specific duty and responsibility, is called to make his contribution so that the dignity of these brothers and sisters may be recognized, respected and promoted.

Duc in altum! This invitation of Christ to Peter and the Apostles I address to the Ecclesial Communities spread throughout the world and in a special way to those who are at the service of the sick, so that, with the help of Mary, *Salus infirmorum*, they will witness to God's goodness and fatherly concern. May the Holy Virgin comfort those who are afflicted by illness and support those who, like the Good Samaritan, soothe their physical and spiritual wounds. I assure each of you that you will be remembered in my prayer, as I willingly impart my Blessing upon you all. *From the Vatican, 8 December 2005*

Benedictus PP. XVI

http://www.vatican.va/holy_father/benedict_xvi/messages/sick/documents/hf_ben-xvi_mes_20051208_world-day-of-the-sick-2006_en.html

Nebraska Bishops' Statement

Affirming the Dignity of the Mentally Ill

Bishop's Statement on Behavioral Health Nebraska Catholic Conference

...Our actions must show that mental illness does not create insurmountable distances, nor prevent relations of true Christian Charity with those who are its victims.

- Pope John Paul II "Mentally Ill Are Also Made in God's Image," 11/30/03

One of the fundamental truths of Christian belief is that each human being is created in the image and likeness of God. (Genesis 1:26-27). The Catholic Church unconditionally embraces and faithfully proclaims this truth. It is the foundation for human dignity. [i] Our commitment to this truth is measured through actions on behalf of the vulnerable and alienated in society, especially the poor and suffering.

Accordingly, as the Diocesan Bishops, shepherds of the Catholic faithful throughout Nebraska, we join together in issuing this pastoral reflection on upholding and respecting the inherent dignity of the mentally ill and those with substance abuse disorders or other addiction problems living in our midst.

We are not experts on behavioral health. [ii] It is a complex, multidimensional subject, encompassing scientific, spiritual and pastoral dimensions. Here, we seek to share our reflections and perspectives as teachers and pastors, in order to encourage those who are struggling with these burdens in any way and to educate the diverse Catholic community on the importance of looking upon our afflicted brothers and sisters with compassion and care.

As pastors, we realize the impact that mental illness, substance abuse disorders and other addiction problems have on individuals, families, communities and the social order. This impact, whether expressed in terms of treating these conditions or in terms of promoting positive behavioral health practices, gives rise to numerous considerations: mental, emotional, physical, social, moral and spiritual.

There are inevitable relations and interactions among these different areas of functioning. For example, it is certainly plausible that psychological problems may be

triggered, exacerbated or maintained by moral and spiritual problems in a person's life. In this regard, the Church and the profession face an ongoing challenge in considering ways that spiritual and moral guidance may be integrated in the process of healing and recovery. In particular, we are aware of the Church's potential contributions to the process of healing and recovery through the sacramental, spiritual and moral dimensions of her ministry. Nevertheless, we believe it is never appropriate to assume that mental illness and/or substance abuse disorders or other addiction problems are directly or necessarily related to a person's moral or spiritual life.

Connections of this kind are typically complicated and difficult to discern, even for those with significant training and expertise in these matters.

The Focus of Concern

Those who are by diagnosis "mentally ill" are not the only concern of this statement. We have in mind a broader category of brothers and sisters whose well-being is diminished: adults who suffer from chronic or severe and disabling mental illness, youth with serious emotional disorders, all those with any psychological disorder, and those who are chemically dependent, either separate from or in conjunction with mental illness. We understand that it is not uncommon for substance abuse or addictions to be associated with other forms of mental illness, which is delineated as "dual diagnoses" or "co-occurring illness."

With regard to mental illness itself, there are commonly identified and discussed disorders, such as severe depression, schizophrenia, bi-polar affective disorder, delusional disorder and obsessive-compulsive behavior. The *Diagnostic and Statistical Manual of Mental Disorders* (4th edition), regarded as a standard for mental health professionals, contains a catalog of the clinical symptoms for 365 different mental disorders. [iii]

Practically, these disorders are often manifested in behavior regarded in everyday settings as odd, bizarre or nonconforming, including such traits as anger, agitation, anxiety, panic, stress, disorientation, confusion and despair. These behaviors often cause people to feel offended or ill at ease, to say the least, regardless of how involuntary such behavior might be.

It is sad, but true nonetheless, that mental illness, substance abuse disorders and other addiction problems are often stereotyped and stigmatized. This stigma can, and often does, spawn uncharitable, un-Christian attitudes and reactions of indifference, neglect, disdain, exploitation, even abuse and violence. It is as if those who are

afflicted are somehow uniquely and solely responsible for their actions and behavior. Each of us, as individuals, citizens, relatives and neighbors, and certainly as believers in Christ's message, should sincerely reflect upon our own attitudes towards those who are afflicted by any form of mental illness and/or substance abuse disorders or other addiction. Rather than contributing to any sense of shame and stigma, we can, instead, work to erase it. We can reach out in compassion to help those so afflicted overcome these barriers, which hinder them in seeking their own well-being.

Connection to Crime

The impact of mental illness, substance abuse disorders and other addiction problems is felt in another context: the interrelatedness they have with crime and the criminal justice system.

Untreated mentally ill persons comprise a disproportionately large segment of the criminal justice population in the United States. [iv] Nationwide, it is estimated that as many as 200,000 of the two million individuals who are incarcerated at any one time suffer from some form of mental illness.[v] Moreover, those incarcerated also have a very high rate of substance abuse, perhaps as high as 85 percent. [vi]

In November 2000, we joined our brother Bishops throughout the United States, in issuing a well-received pastoral statement entitled, *"Responsibility, Rehabilitation and Restoration: A Catholic Perspective on Crime and Criminal Justice."* In it we stated:

"...Crimes are sometimes committed by individuals suffering from serious mental illnesses. While government has an obligation to protect the community from those who become aggressive or violent because of mental illness, it also has a responsibility to see that the offenders receive the proper treatment for his or her illness. Far too often mental illness goes undiagnosed, and many in our prison system would do better in other settings more equipped to handle their particular needs." [vii]

Rights as an Image of God

A Vatican-sponsored international conference in 1996 was devoted to the following theme: *"In the Image and Likeness of God: Always? Illness of the Human Mind."* Pope John Paul II addressed this conference and described its theme in these words:

"Whoever suffers from mental illness 'always' bears God's image and likeness in himself, as does every human being. In addition he 'always' has the inalienable right not only to be considered as an image of God and therefore

as a person, but also to be treated as such.... The Church looks on these persons with special concern, as she looks on any other human being affected by illness.”[viii]

In his address, the Pope set forth guidance that all can take to heart:

“It is everyone’s duty to make an active response: our actions must show that mental illness does not create insurmountable distances, nor prevent relations of true Christian charity with those who are its victims. Indeed, it should inspire a particularly attentive attitude towards these people who are fully entitled to belong to the category of the poor to whom the kingdom of heaven belongs. (cf Mt. 5:3)”[ix]

Nebraska Pursues Major Reforms

It can be reasonably estimated that more than 100,000 Nebraska residents are coping with some form of mental health, substance abuse and/or addiction problem. This estimated number would include nearly 70,000 adults and youth with serious mental illness and serious emotional disorder respectively, as well as nearly 20,000 individuals with substance abuse disorders. [x] These fellow Nebraskans reside throughout the state. Not all live in cities and towns, or east of Highway 81. These human stories are rural realities and concerns as well. In some cases they are experienced in ways related more specifically to rural lifestyles, rural experiences and pressures from uncertainties in agriculture.

Jointly and compassionately, we hereby extend and express our prayers and sincerest wishes for relief to all Nebraskans who are burdened by mental illness and/or substance abuse disorders or other addiction problems, and to their loved ones, who often suffer with them. Our faith leads us to understand that your suffering can be joined in God’s plan to that of Jesus Christ, who, in His human nature, took all human suffering unto himself, whether suffering of body, mind or spirit. Yet, those suffering in this way, to reiterate the Holy Father’s instruction, “always” bear God’s image and likeness.”

As teachers, we emphasize the duty to recognize and respect the worth and dignity of human beings. We challenge the citizenry of Nebraska to embrace this duty by supporting and serving all those who find themselves in a condition of mental illness and/or substance abuse disorder or other addiction problem. This is a task for which science and faith, medicine and pastoral care; professional skill and a sense of common brotherhood (solidarity) must join hands through an investment of adequate human, scientific and socio-economic resources.[xi]

Here in Nebraska, key policy makers from both governmental and private sectors are currently leading the way toward a major reform of the state's behavioral health system. We applaud their endeavors and extend to them our gratitude, encouragement and best wishes. We joined with others in our support for the legislation (LB 724, 2003; LB 1083, 2004) that sets the course for these ambitious, but much-needed reforms. We believe that Nebraska is on the right course, setting a tone for renewed efforts, support and participation.

Community Emphasis

A priority goal of Nebraska's efforts to reform its behavioral health system is to ensure improved access to better behavioral health services and improved outcomes for all Nebraskans whose well being is diminished by mental illness and/or substance abuse disorders or other addiction problems. A foremost approach for pursuing this goal, in addition to maintaining the necessary inpatient services, is investment in statewide development of community-based behavioral health services, including enhanced facilitation of assisted outpatient and assertive community treatment, making it possible for people to be served in their home communities. We endorse this approach. From our perspective, as pastors and teachers, it is consistent with important themes of Catholic social teaching, most notably subsidiarity and the call for solidarity. Accordingly, various Catholic ministries and parish outreach efforts are collaborating in this approach and can improve upon that collaboration as efforts continue to develop.

This increased emphasis on community-based behavioral health care is an important and commendable shift in policy and approach, involving more than the anticipated creativity, flexibility, integration of services and cost effectiveness. It also involves community values and action, including breaking down stereotypes, lessening stigmas, promoting recovery-oriented treatment responses, assisting family cohesiveness, encouraging neighborliness, and enabling more extensive and rapid reintegration of patients as productive citizens.

Policy makers have already made a number of key decisions relating to Nebraska's behavioral health reform. Many more decisions will have to be made, and additional challenges will be faced as decisions are implemented, linkages established and effects evaluated. Troublesome funding issues will have to be resolved, including integration and allocation of public funding: federal, state and local. Ongoing private-sector involvement, through partnerships with government and philanthropic endeavors, will warrant facilitation and encouragement. Providing for appropriate oversight and accommodating advocacy on the part of stakeholders and other citizens will require attention. Communication and cooperation, including working

relationships among law enforcement, medical personnel and various care providers, will have to be initiated and sustained, in order to ensure that necessary reforms are realized and goals achieved. Public officials and community leaders especially will have to be prepared and responsive in order to ensure the safety of all community members.

Reforms Create Opportunities

Despite daunting tasks and challenges for realizing these reforms, perseverance, patience and persistence on the part of policy makers and administrators, those who serve and those who are served, will shape a new environment as a result of the reform efforts. Community-based services will respond to and produce community-based opportunities.

As new approaches are implemented, there will be opportunities to know more; to understand better; to overcome fears, discomforts and prejudices; to reject stereotypes; to reach out to those who are burdened by their illness rather than to ignore or demean them; to be a friend; to be a neighbor. Community-based services can have great success when those who constitute the communities respond, without fear or prejudice, in service and charity. We believe that Christian service, Christian charity, and Christian witness must flow into these opportunities.

In his encyclical, *Evangelium Vitae*, Pope John Paul II writes of the importance and value of “*daily gestures of openness, sacrifice and unselfish care.*”[xii] Such gestures are reflective of the attitudes we all must have as behavioral health reforms proceed and take hold.

We commit our Catholic community within Nebraska to this cause, encouraging Catholic Nebraskans to put their faith into action as part of the anticipated social transformation.

Moreover, we call upon all Nebraskans of good will to seek and embrace these opportunities, as a realization of the culture of life for all.

Sincerely Yours In Christ,

Most Rev. Elden Francis Curtiss
Archbishop of Omaha

Most Rev. Fabian W. Bruskewitz

Bishop of Lincoln

Most Rev. William J. Dendinger,
Bishop of Grand Island

Approved for Release by the Nebraska Catholic Conference; Meeting at Lincoln, NE
1/26/05

Endnotes

[i] "The dignity of the human person is rooted in his creation in the image and likeness of God." Paragraph 1700, *Catechism of the Catholic Church*, 2nd Edition (Washington, D.C., United States Conference of Catholic Bishops, 2000).

[ii] We recognize that some confusion in discussing these issues stems from the difficulty of deciding upon and using consistently adequate terminology, e.g., "mental illness" and "behavioral health." Whereas the terms may be used interchangeably, the former essentially describes psychological/psychiatric disorder, while the latter is the prevailing terminology in conjunction with Nebraska's public-policy initiatives in this context and specifically includes substance abuse disorders as well as other mental illness conditions.

[iii] C.A. Palmer. *Encyclopedia of Science, Technology and Ethics*. Macmillan, 2004.

[iv] Michele Herman, "Assisted Outpatient Treatment for Mental Illness", LegisBrief, Vol. 12, No. 40 (Washington, D.C., National Conference of State Legislatures, 2004).

[v] U.S. Department of Justice, Bureau of Justice Statistics, Mental Health and Treatment of Inmates and Probationers (Washington, D.C., 1999) as reported in *Responsibility, Rehabilitation, and Restoration: A Catholic Perspective on Crime and Criminal Justice*, United States Conference of Catholic Bishops, 2000.

[vi] Division of Planning, Research and Accreditation, Nebraska Department of Correctional Services, December 2004.

[vii] United States Conference of Catholic Bishops, *Responsibility, Rehabilitation, and Restoration: A Catholic Perspective on Crime and Criminal Justice*, (Washington, D.C., 2000).

[viii] Pope John Paul II, *Mentally Ill Are Also Made in God's Image*, address to participants in the international conference sponsored by the Pontifical Council for Pastoral Assistance to Health-Care Workers, (Vatican City, 11/30/03).

[ix] Pope John Paul II, *Mentally Ill Are Also Made in God's Image*, (Vatican City, 11/30/03).

[x] Information extrapolated from *Nebraska Mental Health Statistics Improvement Program: Prevalence, Utilization and Penetration*, WICHE Mental Health Program, report for Division of Mental Health, Substance Abuse and Addiction Services, Nebraska Health and Human Services System, October 30, 2001.

[xi] Pope John Paul II, *Mentally Ill Are Also Made in God's Image*, (Vatican City, 11/30/03).

[xii] Pope John Paul II, *The Gospel of Life (Evangelium Vitae)*, No. 27, (Vatican City, 1999).

Web Links

Catholic Resources

National Catholic Partnership on Disability (NCPD) - www.ncpd.org

Mental Illness Ministries, Archdiocese of Chicago – www.miministry.org

Faith in Recovery - www.faithinrecovery.com

CUSA – www.cusan.org

Interfaith Resources

Pathways to Promise - www.pathways2promise.org

National Alliance on Mental Illness FaithNet (NAMI Faithnet) -
www.nami.org/namifaithnet

Chaplain Craig Rennebohm -
http://www.mentalhealthchaplain.org/MHC_chaplain.htm

Mental Health Ministries, Rev. Susan Gregg-Schroeder -
www.mentalhealthministries.net

Secular Resources

National Alliance on Mental Illness (NAMI) – www.nami.org

U.S. Government

National Institute on Mental Health (NIMH) - www.nimh.nih.gov/index.shtml

Substance Abuse and Mental Health Services Administration (SAMHSA) -
www.samhsa.gov/



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Support Group Models

Faith and Fellowship

Parish-based, small faith-sharing communities with adults whose mental illness is severe and persistent, with trained volunteer mentors. Format consists of quiet, centering activities; reflection, Scripture, and prayer around a given theme (using a book of prepared outlines); and agape table-fellowship. Weekly sessions with volunteer formation/training held alternately with sessions for the whole group.

38 N. Austin Blvd., Oak Park IL 60302
708-383-9276
miministry.org
faith_fellowship@hotmail.com

Faith in Recovery

Assists parishes to develop mental health programs suited to its members, providing mutual support and education, involving the community and emphasizing a mind-body-spirit understanding of mental illness, and decreasing stigma. Various formats are used, including sharing and support, speakers on topics of interest, holding a healing service, showing videotapes or reading a selected book. A toolkit is available on their web page.

4415 W. Forest Home Avenue, Milwaukee, WI 53219
414-329-9100
www.faithinrecovery.com
faithinrecovery@sbglobal.net

Portland Faith Sharing

Monthly faith sharing group (weekly during Lent) features a lunch with time to informally visit and build relationships, followed by reflection on the upcoming Sunday readings. Led by a pastoral facilitator, group members take turns giving the readings, followed by a reflection question to initiate sharing; personal prayers of intercession and thanksgiving, and sometimes song, are also part of the format.

Archdiocese of Portland
Office for People with Disabilities
503-233-8399
dcoughlin@archdpdx.org

St. Dymphna Society

Quarterly meetings provide devotional, educational, and supportive faith community for persons with mental illness, families, friends, and care providers. Each meeting consists of prayers (including intercession to St. Dymphna), discussion, and often a video, speaker, or other educational resources. An annual Mass is held in May, with a blessing with a relic of St. Dymphna and hospitality.

6309 N. Knox, Chicago, IL 60646
773-777-6022
theweb@mindspring.com

Soup for the Soul

Monthly interfaith spirituality support group hosted by a local social service agency. Following a simple soup lunch, discussion on spiritual themes as they relate to mental health issues is led by a trained mental health facilitator. Sessions last one hour and embrace a wide range of faith traditions, including Catholic. The Diocese of Erie, Pennsylvania, was instrumental in establishing this group.

Mental Health Association of Northwestern Pennsylvania
1101 Peach Street, Erie, PA 16501
814-452-4462
www.mhanp.org



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About National Catholic Partnership on Disability (NCPD)

The National Catholic Partnership on Disability (NCPD) was established in 1982 to foster implementation of the *Pastoral Statement of U.S. Catholic Bishops on People with Disabilities*. Passed unanimously on November 16, 1978, this prophetic document calls for welcome of the now over fourteen million Catholics who live with disabilities. It states that persons with disabilities must be able to participate in the celebrations and obligations of their faith, and advocates for their inclusion "within the total fabric of society." NCPD is guided by a Board of Directors representing a cross-section of the Church, including Episcopal Moderator Daniel Cardinal DiNardo, Bishop Michael Driscoll, diocesan directors of disability ministry, people with disabilities and family members, pastoral workers, and other concerned individuals. The NCPD Board formulates policy statements and resolutions that direct NCPD's work in carrying out the mission statement that reads:

Rooted in Gospel values that affirm the dignity of every person, the National Catholic Partnership on Disability (NCPD) works collaboratively to ensure meaningful participation of people with disabilities in all aspects of the life of the Church and society.

In addition to the NCPD Board, several Councils and Task Forces provide additional input for its direction, including a Council on Mental Illness.

This work for the inclusion of disabled persons moves forward through a national network of diocesan level leaders called by their bishops to address access and inclusion within parishes supported by NCPD's Executive Director and staff. Much of the support of the diocesan level leaders is accomplished through consultation and the provision of ministry-specific resources that address the various topics of ministry that are encountered at the parish level, as exemplified by the production of *Welcomed and Valued*.

As a private, non-profit organization, NCPD relies on donations from affiliate member (arch) dioceses, foundations and donors. For more information on NCPD's programs which support a range of ministries, serving clergy with visual impairments, as well as persons with autism, Down Syndrome, celiac disease, mental illness and physical and developmental disabilities, contact us at www.ncpd.org.

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202-529-2933 (v) 202-529- 2934 (tty) 202-529-4678 (fax)

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Adult and Forensic Psychiatrist
Portland, OR

Mission:

Following Jesus who embraced all, we assist the Catholic Community in reaching out to and accompanying our brothers and sisters with mental illness and their families, assuring their rightful place in the Church and society.