



CATHOLIC
MENTAL HEALTH
MINISTRY
Guidelines for
Implementation

Second Edition

Edited by:

Wendell J. Callahan, PhD

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CATHOLIC MENTAL HEALTH MINISTRY:

GUIDELINES FOR IMPLEMENTATION

SECOND EDITION

Editors

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University of San Diego Catholic Institute for Mental Health Ministry



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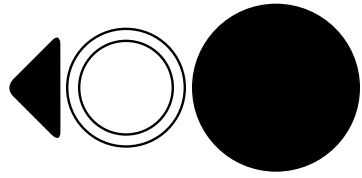
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This edited volume on Catholic Mental Health Ministry stands as a testament to the collaborative efforts and unwavering dedication of numerous individuals who have contributed their time, expertise, and passion to this vital endeavor. The successful compilation of this book would not have been possible without the invaluable contributions of clergy, mental health professionals, and lay ministry leaders from Catholic dioceses and parishes across the United States.

We extend our deepest gratitude to the clergy members who have offered their spiritual guidance and wisdom, infusing this work with a profound sense of faith and compassion. Your insights have been instrumental in shaping the spiritual foundation upon which this book rests.

To the mental health professionals who have generously shared their expertise, thank you for your tireless commitment to understanding and addressing the complexities of mental health within the Catholic community. Your clinical acumen and compassionate care have greatly enriched the content of this volume. A special appreciation goes out to the lay ministry leaders who have provided invaluable perspectives and practical insights, demonstrating the power of grassroots initiatives in building a more inclusive and supportive Catholic community.

Thank you all for your dedication to the *movement* that is Catholic Mental Health Ministry. Your collective efforts have not only enriched this book but also contributed to the ongoing dialogue surrounding mental health in our faith community.

With heartfelt appreciation,
Wendell J. Callahan, PhD
San Diego, CA

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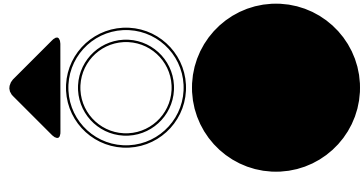
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FOREWORD

MOST REVEREND BISHOP JOHN DOLAN

I was pleased to serve as an advisor to the Catholic Institute for Catholic Mental Health Ministry through the Department of Counseling and Marital and Family Therapy located at the University of San Diego and to be a contributor to the First Edition of the Catholic Mental Health Ministry: Guidelines for Implementation (*guidelines*) back in 2019.

While the basic methodology toward forming effective diocesan, parish, and school-based mental health ministries remains, much has changed since the original edition of these *guidelines*. Since 2019, our world and church have endured a pandemic, major wars in Ukraine and the Holy Land, significant changes in weather patterns, a very heated political stage in the United States, and escalating refugee population patterns here and abroad.

On a personal note, my appointment as Bishop of Phoenix in August of 2022 and my sister Mary's death by suicide in October of the same year have led me to a profound trust in our God who accompanies us even in the most difficult trials of our lives.

As I consider the global, national, and personal concerns which have affected my own mental wellness, I am blessed to know that I

play some part in helping to shape a much-needed ministry within the life of our Church and society. I believe, more than ever, that Mental Health Ministry is a necessary way of life within the mission of Christ and His Church.

Since the first edition of these *guidelines*, major developments have also occurred in the fields of psychiatric and psychological services, national and international programs for mental health ministries have been implemented, and a greater ecclesiastical trust has grown of psychology as a science that, along with faith, points to the same end – God himself, who makes all things new.

Since the global pandemic, for example, certain breakthroughs in mental healthcare have included blood tests for brain-derived neurotrophic factors, artificial intelligence and virtual reality aids to assist in decreasing pain and anxiety, and an increase in telehealth in order to seek counseling virtually.

Through the Catholic Institute for Mental Health Ministry and the Association of Catholic Mental Health Ministries (CMHM) there has been an increase in diocesan and parish-based mental health ministries in the United States and many other countries.. This implementation has caught the attention of the United States Conference of Catholic Bishops, which in turn established the first ever National Catholic Mental Health Campaign (CMHM) and Novena for Mental Health in October of 2023. Additionally, the Vatican's Dicastery for Promoting Human Integral Development continues to work with the CMHM on a pathway toward promoting mental health ministry on a global level.

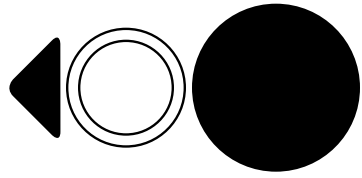
These continual breakthroughs in faith and the field of science will – I am convinced – continue to create a level of trust in the field of psychiatry among Catholics and people of good will, to eradicate

the stigma associated with mental disorders and anxieties, and to accompany our family and friends who long to know they have a place at the table as they navigate their mental wellness.

I pray that these *guidelines* will serve as an aid to those of you who wish to begin mental health ministries in your own dioceses, parishes, and institutions. I also trust that this new edition will assist those of you who are well underway in this important work within the life of the Church.

May Saint Dymphna, Patroness of those with Mental Illness, be with you!

Most Rev. John P. Dolan
Bishop of Phoenix



INTRODUCTION

A RATIONALE FOR CATHOLIC MENTAL HEALTH MINISTRY

WENDELL J. CALLAHAN

St. John wrote, “The thief comes only to steal and kill and destroy. I have come so that they may have *life* and have it to the full.” For many Catholics suffering from mental illness, the stigma, shame, and in some cases shunning they experience creates a barrier to engaging meaningfully in the life of the Church, moving closer to Christ, and indeed living life to the fullest. Our intention in this volume is to compile and present resources for lay ministers and clergy to thoughtfully and effectively implement mental health ministries in dioceses and parishes. Guided by a scholarly review of relevant literature regarding Mental Health Ministry as well as our own fieldwork observing and learning best practices, we offer this resource as a “playbook” to assist our fellow ministers in successfully beginning and developing their ministries. While this work is informed by the scholarly and research literature, we intentionally wrote this in an accessible style typical of instructional texts. This is

not meant to be an academic treatise, rather our intention is for readers to put the content of this volume into practice.

Our work is also guided by the simple and compelling six principles outlined in the 2018 volume *Hope and Healing: A Pastoral Letter from the Bishops of California on Caring for Those Who Suffer from Mental Illness*. These principles are:

Principle 1. *Christ calls us to attend to those who suffer from mental illness and provide hope and healing.* With this in mind, the first three chapters of this manual cover the basics of Mental Health Literacy, which we judge to be a necessary requisite for those participating in Mental Health Ministry. Indeed, to attend to those coping with mental health problems, a basic understanding of mental health, common vocabulary, and the process to initiate appropriate referrals is required.

Principle 2. *The scope and burden of mental illness in our society is enormous. We are all affected by mental health concerns.* The experience of depression and anxiety are common to our emotional life as humans and how we learn to cope and adapt to these experiences is often a lifelong process. Additionally, the impact of severe mental illness is often either felt directly in our lives or indirectly through the suffering and struggles of a loved one. Mental health problems are common, and treatments are available. An active Mental Health Ministry equips the Church to help connect parishioners with appropriate referrals as well as to provide prayerful accompaniment as parishioners navigate treatment, crisis, and healing.

Principle 3. Those suffering from mental illness should not be stigmatized or judged. Mental illness remains poorly understood even by clergy and others in positions of influence. In the healthcare community, mental illness is viewed as having clear neurobiological and genetic correlates, and treatment for most major psychiatric conditions involves both physical as well as psychological components. Mental illness should never be viewed as the consequence of character flaws or lack of faith. Imagine how ridiculous it would be to judge or stigmatize a parishioner with cancer or assume that a lack of faith caused their illness! Yet we continue to view mental illness as somehow different in its origin. As Catholics, we are called to reach out and embrace all of our brothers and sisters suffering from illnesses, and we need not treat mental illness as different from any other medical condition. Indeed, St. Dymphna is recognized by the Church as patroness of both mental and neurological disorders as well as mental health practitioners and neurologists.

Principle 4. *The Church, health care professionals, and scientific researchers should work together to improve mental health care.* An effective and sustainable response to mental illness in the Church requires a collaborative approach. Here at the Catholic Institute for Mental Health Ministry, we recognize that our work to promote Mental Health Ministry necessitates that we engage meaningfully with clergy, laity, researchers, and practitioners to advance the notion of Mental Health Ministry in the Church.

Principle 5. *We must meet and attend to those in need where they are.* Our sisters and brothers coping with mental illness are sitting next to us in the pews during Mass as well as sleeping in the Church parking lot at night. This means that we should design outreach efforts to both engage known parishioners more deeply as well as connect our efforts to the community around us. How we organize our ministries will determine our degree of success in these efforts.

Principle 6. *Those impacted by suicide need our compassionate response.* Suicide is, tragically, a common symptom as well as complication of mental illness. It needs to be understood as such, with no judgment. Instead, many loved ones of decedents from suicide may live with shame or guilt. Therefore, we must respond with embrace, compassion, love, and prayer. Our response as compassionate and prayfull companions can help to relieve this unnecessary pain and also make our parishes more welcoming and Spirit-filled communities.

We have organized this volume as a companion to inform the implementation of Mental Health Ministry at either the diocesan or parish level. With that said, the methods outlined in this volume should also apply to the implementation of ministries in other Catholic settings, such as schools, colleges, and hospitals. Irrespective of setting, we emphasize in the first section of this book the importance of a common understanding, vocabulary, and specific skills to engage individuals with mental health problems as critically important for an effective ministry. We refer to this as *Mental Health Literacy* and recommend anyone seeking to implement

mental health ministries invest the time in completing a basic eight-hour course (i.e., Mental Health First Aid or equivalent) on this topic.

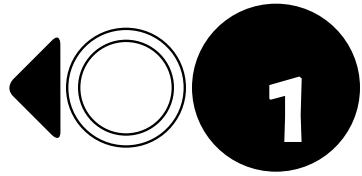
The second section of this volume includes advanced topics in Church teaching, saints who lived with mental illness, liturgical considerations as well as an important discussion of accompaniment for those grieving the loss of a loved one to suicide. Also include in Section II is an important chapter on self-care for mental health ministers as well as continuing education. This ministry can be taxing on both an emotional and intellectual level and this chapter seeks to address some of these challenges. An important and easily overlooked aspect of ministry implementation is the stewardship and ongoing support of ministry team members. We assert that attention to ministry stewardship and attention to the self-care of ministry members will facilitate the sustainability of the ministry.

The third section feature first hand narratives from lay ministers who have implemented ministries in their respective dioceses or parishes. These chapters address the structures, processes, and progress of ministry implementation. Their narratives also include specific strategies for internal ministry as well as how ministry teams evaluated the impact of their ministry. We encourage the reader to reflect on how they will implement the ideas and methods described in this volume in a ministry that will support parishioners' mental health needs in a Catholic, sustainable, ethical and meaningful way.



SECTION I - GETTING STARTED IN MENTAL HEALTH MINISTRY

In this section we cover the basic knowledge or mental health, accompaniment, and implementation essential to plan and begin work in the Mental Health Ministry.



CHAPTER 1

RECOGNIZING THE SIGNS AND SYMPTOMS OF COMMON MENTAL ILLNESSES AND SUBSTANCE USE DISORDERS

WENDELL J. CALLAHAN, LIBERTY HEBRON & ALYSSA

WILLMERDINGER

To build a successful Mental Health Ministry Team, a grounded foundation in Mental Health Literacy is key. Mental Health Literacy is simply defined as a person's knowledge and beliefs about mental illness. There are five main components of Mental Health Literacy: (1) recognizing disorders and signs of psychological distress; (2) knowledge of risk factors, causes, and interventions; (3) awareness of mental health professional support available to the community; (4) attitudes and beliefs that encourage help-seeking behaviors; and (5) acknowledging when to obtain mental health information and guidance (Compton et al., 2011). Keep in mind, a Mental Health Ministry Team is not a clinical team; however, a Mental Health Ministry Team's ability to combine faith-based practice and the use of language, knowledge, and support consistent with Mental Health Literacy can directly influence the attitudes and

perceptions surrounding mental health. Essentially, the goal of improving Mental Health Literacy is to promote the reduction of mental illness stigma, encourage conversations around mental illness, and create a safe environment for individuals to share and seek help surrounding their mental illness.

It is important for the Mental Health Ministry Team to practice and increase the use of Mental Health Literacy, as clergy and ministers are often the “first line of defense” or “first contact” for those suffering from mental illness, and this initial experience can shape an individual’s perception of seeking help within the parish and/or seeking help in the community (Vermaas et al., 2017; and Wang et al., 2003). Think of the Mental Health Ministry Team as “Gatekeepers” (Mason et al., 2016). With research pointing to people of diverse backgrounds identifying help from clergy or church communities as more comfortable than seeking direct help from mental health professions, the Mental Health Ministry team has a responsibility to be familiar with a general understanding of common signs and symptoms of mental illness, be able to gather a sense of a presenting concern/issue and risk factors, and have knowledge of local services and community resources.

The National Alliance on Mental Health (NAMI), a nationwide advocacy group for individuals with mental illness and supporter of education of mental illness, presents common signs and symptoms generally associated with depressive disorders, anxiety disorders, substance use, psychotic disorders, bereavement, family problems, and suicide. The charts that follow (from NAMI, 2019) can assist with improving mental health literacy.

COMMON SIGNS AND SYMPTOMS FOR MENTAL ILLNESS

- Excessive worrying or fear
- Feeling excessively sad or low
- Confused thinking or problems concentrating and learning
- Extreme mood changes, including uncontrollable “highs” or feelings of euphoria
- Prolonged or strong feelings of irritability or anger
- Avoiding friends and social activities
- Difficulties understanding or relating to other people
- Changes in sleeping habits or feeling tired and low energy
- Changes in eating habits such as increased hunger or lack of appetite
- Changes in sex drive
- Difficulty perceiving reality (delusions or hallucinations, in which a person experiences and senses things that don’t exist in objective reality)
- Inability to perceive changes in one’s own feelings, behavior, or personality (“lack of insight” or anosognosia)
- Abuse of substances like alcohol or drugs
- Multiple physical ailments without obvious causes (such as headaches, stomach aches, vague and ongoing “aches and pains”)
- Inability to carry out daily activities or handle daily problems and stress
- Thinking about suicide

As stated, the Mental Health Ministry does not diagnose and treat mental illness. The purpose of providing Mental Health Literacy is to educate about mental health challenges. The Mental Health Ministry Team must be able to provide spiritual support and

recognize warning signs of mental illness that must be treated professionally. Having a general idea of signs and symptoms as well as a basic understanding of what common disorders look like will help teams to know when to appropriately refer and/or encourage professional treatment. Research shows that people most often seek clergy assistance with the following concerns: depression, anxiety, substance use, bereavement, and marital problems. Less frequently sought out concerns, yet equally important, include psychotic disorders and suicide thoughts/attempts. For your knowledge, use the following chart (Suicide Risk) to reference key characteristics of depression, anxiety, substance use, psychotic disorders, and bereavement.

SUICIDE RISK
● Threats or comments about killing themselves, also known as suicidal ideation, can begin with seemingly harmless thoughts like “I wish I wasn’t here” but can become more overt and dangerous ● Increased alcohol and drug use ● Aggressive behavior ● Social withdrawal from friends, family, and the community ● Dramatic mood swings ● Talking, writing, or thinking about death ● Impulsive or reckless behavior ● Putting their affairs in order and giving away their possessions ● Saying goodbye to friends and family ● Mood shifts from despair to calm

- Planning, possibly by looking around to buy, steal, or borrow the tools they need to complete suicide, such as a firearm or prescription medication

From a faith-based or religious perspective, suicidality (i.e., an individual's tendency to experience and/or express suicidal thoughts, gestures, or attempts) is perhaps one of the most daunting aspects of the expression of mental illness. We have described common signs of suicide risk in the previous table so that there can be clarity around what suicidality can look like. There is increased societal concern that the occurrence of suicide is on the rise, especially for younger, more diverse populations. The topic cannot be avoided. We understand that death, in and of itself, is a difficult topic to discuss. When an individual takes their own life, the conditions of death, and even the grief that follows, is complicated. Simply put, we hope you consider that suicidality and suicide risk are *symptoms* of various mental health disorders, most notably depression. If a person's death were noted to be a result of "complications from cancer," we would feel tinges of sorrow and sympathy. If a person's death is described as a result of "complications from depression," also known as suicide, we should feel the same and remain wary of any judgments or exclusions. After all, the individual who has taken their own life has most likely suffered enough judgment and exclusion in their life.

To guide your knowledge and pursuit of Mental Health Literacy, we have compiled the following to outline the common mental health disorders that may be witnessed through Mental Health Ministry. Again, the purpose of this is not for you to be prepared to treat mental illness, but so that you can be informed and

able to recognize psychiatric disorders as you engage in ministerial relationships and service to others.

Recognizing signs, symptoms, and risk factors can be challenging. Sometimes initial referrals or presenting concerns may not reflect ultimate psychiatric diagnosis. Some presentations may be more direct. For example, substance use problems tend toward substance use disorder. However, other presentations, such as anger, agitation, work problems, or relational problems, can speak toward a variety of psychiatric disorders. Even among highly trained physicians (non-mental health professionals), recognizing the signs and symptoms of mental illnesses can be difficult. Primary care physicians identified psychiatric disorders in their patients with an average 41.5% accuracy (Su et al., 2011). Physicians do not use structured assessments to determine psychiatric disorders, and neither will clergy or Mental Health Ministers. What is important is to recognize and support an individual with a presenting mental illness concern, and follow-through when referral to mental health professionals is necessary.

COMMON PSYCHIATRIC DISORDERS, SIGNS AND SYMPTOMS

DEPRESSIVE DISORDERS & RELATED CONCERNS	FORMAL SYMPTOMS (DSM-V)*	SIGNS TO LOOK FOR
<i>Major Depressive Disorder or Persistent Depressive Disorder (“Depression”)</i>	● Feeling sad, empty, or hopeless for most of the day on most days	● Tearfulness or easily upset (people will describe someone

	● Reduced interest or pleasure in all or mostly all activities ● Fatigue or loss of energy ● Feelings of worthlessness ● Difficulty concentrating or indecisiveness ● Thoughts of death or suicidality (<i>explained below</i>)	as sensitive or reactive) ● Isolation (including neglect of responsibilities, withdrawing from or avoiding social interactions) ● Changes in appetite (leading to weight loss or weight gain) ● Restlessness and agitation (or in others, sluggishness and lethargy) ● In children, increased problematic school behaviors
<i>Suicidality</i>	● Thoughts of death ● Visions or “fantasies” of death or dying ● Desire to die (with or without a plan) ● Attempt to take one’s life	● Indirect statements: “My life is over”; “I wish things were different”; “Things would be better if I were gone”; “I can’t keep going.”

		● Direct statements: “I don’t want to live anymore”; “I wish I were dead”; “I want to die.” ● Careless or reckless behavior despite knowing the consequences ● Access to or collecting methods to take one’s life
ANXIETY DISORDERS & TRAUMA- AND STRESSOR-RELATED DISORDERS	FORMAL SYMPTOMS (DSM-V)*	SIGNS TO LOOK FOR
<i>Generalized Anxiety Disorder</i>	● Excessive or uncontrollable worry or fear that “something bad will happen” ● Restlessness or feeling “on edge” ● Difficulty concentrating—racing thoughts or mind goes blank ● Muscle tension ● Sleep problems	● Leg shaking ● Nail-biting or nail-picking

<i>Posttraumatic Stress Disorder (PTSD)</i>	● Exposure to actual or threatened death, serious injury, or sexual violence (either personally experiencing, witnessing, or being exposed to trauma) ● Reoccurring and uncontrollable disturbing memories ● Reactions as if re-experiencing the trauma ● Intense distress or reactivity to cues related to the trauma ● Concentrated effort to avoid cues related to the trauma ● Consistent negative emotional state (fear, anger, guilt, shame)	● Social withdrawal ● Irritable or angry outbursts ● Panic or extreme discomfort with or without known stimuli ● Reckless or self-destructive behavior
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	● Feelings of detachment from others ● Sleep problems	
SUBSTANCE USE DISORDERS	FORMAL SYMPTOMS (DSM-V)*	SIGNS TO LOOK FOR
<i>Alcohol Use Disorder</i>	● Alcohol is often taken in larger amounts or over a longer period than was intended ● Desire or unsuccessful efforts to cut down or control alcohol use ● A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects ● Craving, or a strong urge to use alcohol ● Recurrent alcohol use in situations in which it is	● Irritability ● Blackouts or loss of recollection during binge-drinking episodes ● Frequently hungover ● Choosing drinking over other responsibilities and obligations ● Drinking alone or in secrecy ● Becoming isolated and distant from friends and family members ● Codependency of loved ones: excessive emotional reliance on disordered person as noted by

	physically hazardous ● Tolerance, as defined by either: a need for noticeably larger amounts of alcohol to achieve intoxication or desired effect, OR a lowered effect with continued use of the same amount of alcohol ● Withdrawal, as evidenced by to following after individual ceases alcohol consumption: trouble sleeping, sweating, nausea, shaking or hand tremors, feeling restless, anxiety	poor boundaries and attempts to control, enable, or defend the actions of the individual with substance use disorder
PSYCHOTIC DISORDERS	FORMAL SYMPTOMS (DSM-V)*	SIGNS TO LOOK FOR
<i>Schizophrenia</i>	● Delusions—belief in something false and unlikely	● Social withdrawal ● Deterioration of personal hygiene

	despite evidence to the contrary ● Hallucinations—sensory perceptions an individual experiences in absence of stimuli ● Disorganized speech—tangential, unclear ● Decline in daily functioning ● Staring, flat facial expression, or appearing “frozen” ● Apathy ● Disinterest or lack of motivation to participate in activities ● Lack of social interest	● Flat, expressionless gaze or low reactivity ● Inability to cry or express joy or inappropriate laughter or crying ● Oversleeping or insomnia ● Forgetful, unable to concentrate
OTHER MENTAL HEALTH ISSUES	FORMAL SYMPTOMS (DSM-V)*	SIGNS TO LOOK FOR
<i>Bereavement</i>	● Mood or changes in functioning or behavior after the	● Depressive symptoms, including: sadness, unexpected crying,

	loss of close person or loved one	isolation, changes in appetite ● Questioning or seeking meaning in life and death ● Anger, irritability, or high reactivity (especially in children) ● Changes in energy ● Thoughts of death or dying
<i>Situational Adjustment</i>	● Emotional or behavioral changes after the experience of an identifiable stressor ● Examples of situational stressors can include: loss of job or significant relationship (i.e., divorce), move or relocation with lack of support, change due to medical diagnosis	● Signs of depression or anxiety (as previously noted) ● Verbal reactivity ● Reckless behavior or changes in inhibition/control ●

<i>Family Problems</i>	● Marital concerns, including but not limited to: poor communication, significant financial burdens, difficulty with sexual intimacy or reproductive problems, suspicion of infidelity ● Separation or divorce ● Concerns for children's problematic behavioral patterns ● Miscarriage or death of a child	● Codependency (as previously defined) ● Frequent arguing ● Unproductive problem solving ● Attempts to maintain secrecy ● Changes in behavioral patterns - i.e., canceling or avoiding commitments (in children, refusal to attend school)
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*Not all diagnostic criteria/symptoms have been listed, from the *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-V; American Psychiatric Association, 2013).

CHAPTER 1 ENRICHMENT ACTIVITY

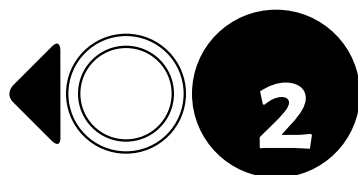
For personal and/or team reflection, examine the following questions:

“We hope you consider that suicidality and suicide risk are *symptoms* of various mental health disorders, most notably depression.” Reflect on your reactions, perceptions, and beliefs about suicide. Discuss as a group and identify what knowledge must be

gained to further prepare for working with others experiencing suicidality or who have lost a loved one to suicide.

Using the five components of Mental Health Literacy, rate or assess your own level of literacy.

What are potential ways in which Mental Health Ministry can respond to individuals displaying signs of the common psychiatric disorders outlined in this chapter (including scripted responses, programmatic planning, and prayer-based interventions)?



CHAPTER 2

REDUCING STIGMA, ENGAGING APPROPRIATELY AND RESPECTFULLY;

DE-ESCALATING CRISIS SITUATIONS SAFELY

WENDELL J. CALLAHAN, LIBERTY HEBRON & ALYSSA

WILLMERDINGER

Saint Paul reminds us in his first letter to the Corinthians that through our baptism, we are “one body with many parts.” We all have unique backgrounds, talents, gifts, and knowledge to offer. By embracing diversity as a strength, there can be learning, growth, and authentic fellowship in any ministry program. The same acknowledgment of the multitude of mental health issues is necessary for us to thrive as one body of Christ. However, embracing mental health challenges can be difficult due to biases and beliefs that develop over time. Within the context of a faith-based congregation, some may have difficulty reconciling the omnipotent and healing power of God with the presence and course of disease, especially the often-misunderstood and mysterious origins of mental health disorders. It is important, therefore, for Mental Health Ministry

Teams to work to address the stigmas surrounding mental health and approach sensitive situations with careful consideration.

As the Mental Health Ministry Team forms, each individual should take the time to identify personal beliefs, attitudes, and mindsets regarding mental health. Each person's background and depth of exposure to a variety of mental health conditions will inform these personal beliefs. Those with lived contact and experience with psychological issues may come in with a perspective that is intimately informed in some areas of mental health, but not fully developed in other areas. As such, it is important for Mental Health Ministry Teams to communicate within the group—to share knowledge, admit concerns, challenge attitudes, and continually grow and develop without limit. The most productive Mental Health Ministry Teams will constantly find themselves doing internal check-ins as individuals and as a group.

Mental Health Literacy is a powerful tool in combating mental health stigma. Making Mental Health Literacy a priority for all ministers and parish staff, not just those working within the Mental Health Ministry Team, will ensure that any parishioner accessing church services will find a safe space, therefore potentially improving help-seeking behavior in those with mental health concerns (Campbell & Littleton, 2018). Providing education and distributing information to the whole congregation will also assist in creating an environment and community where mental health misperceptions are challenged. When the parish as one unified Church is open to dialogue about mental health, the impact is far reaching. Because mental health concerns can affect anyone, of any background or culture, having a parish-wide and systemic approach to remaining

informed about mental health will support the Mental Health Ministry in countless ways.

With all clergy, parish staff, ministers, and volunteers maintaining basic Mental Health Literacy, and the Mental Health Ministry Team providing more in-depth knowledge and accompaniment, the mental health needs of the parish can be addressed. It is known that churchgoers with mental health concerns, especially those of minority populations, prefer to seek help from clergy (Vermaas et al., 2017). The same research study identified that, in particular, African Americans, Asian Americans, females, the elderly, and veterans may display help-seeking behavior through parish venues. While the Mental Health Ministry calls us to welcome, embrace, and accompany parishioners of various backgrounds, the Mental Health Ministry Team has a responsibility to pay special attention to these populations for the purpose of anticipating mental health needs and potential referral.

As a team preparing to serve the mental health needs of your parish, it is important to remain sensitive and take basic considerations to approach mental health concerns respectfully. For example, language can play a role in supporting Mental Health Ministry efforts and reducing stigma. Simply shifting from identifying someone as “mentally ill” to saying that someone “has a mental health disorder” or is “experiencing mental health difficulties” can greatly reduce negative connotations. Above all, a person with a mental health disorder should never be referred to as the diagnosis (e.g., “She’s borderline” or “He’s bipolar”). Such language is both demeaning and inaccurate. A person is never a diagnosis, whether medical or psychological. Ministers should not be afraid to use language that is presented by the person they are serving

while providing consistent fact-based information. For example, if a person has a mental health diagnosis, it can be said that the person has depression, which brings a multitude of complicated symptoms, as opposed to simplifying or devaluing the complexity of the person's experience by saying, "They're just depressed." Likewise, someone who has experienced trauma is often labeled as a "victim." This connotes that the person remains injured, broken, or perpetually victimized. In contrast, referring to this person as a "survivor" will empower them to continue in their recovery and success, as well as inspire supporters to treat the person in a strengths-focused manner. There are many language and paradigm shifts that will help your team to create safe, respectful, and welcoming environments for the church community.

Long-Term Care vs. Short-Term Crisis Intervention

As stated, research has shown that churchgoers are drawn to seek help for mental health needs from clergy and ministers (Vermaas et al., 2017). Church services are not tied to health insurance or health services bureaucracy. Therefore, parishioners can find immediate assistance for their mental health concerns without the need for prior approval or referral, concern for payments and fees, or the presumed involvement of other agencies. Additionally, especially due to the vows maintained around the sacrament of Reconciliation, people assume that seeking help from clergy comes with a level of confidentiality and, therefore, might proceed to seek help with a sense of security and comfort. Knowing this, Mental Health Ministry Teams should be prepared to respond to those at every stage of help-seeking behavior: from those with an immediate

crisis and high need for assistance to those who have had or will have a long journey with a chronic or long-term mental health condition.

Those seeking support in later stages of a psychiatric condition (i.e., they or a loved one have a recognized condition, have been diagnosed, and/or have entered treatment for a mental health issue) will be best served through the accompaniment of Mental Health Ministers. By providing a place for vulnerable conversations and informed and intentional responses, the Mental Health Ministry Team can help combat one of the most universal effects of dealing with mental health concerns—the sense of isolation. Those who need long-term support for mental health afflictions may seek spiritual companionship from Mental Health Ministers. It is understandably easy to question God’s presence and intention when facing mental health difficulties. Whether it is through faith-based reflection and discussion, attending meetings or groups with those in need, or maintaining prayer intentions, Mental Health Ministry Teams can find many ways to accompany those with long-term mental health needs.

If faced with immediate crisis situations, Mental Health Ministry Teams have much to consider. There may be times when churchgoers, feeling most comfortable and confident in finding solace from a Mental Health Minister, come forward with a serious concern or crisis either they or a loved one are facing. A mental health crisis will require careful response depending on the situation. A mental health crisis can be recognized by some of the following signs:

- ❑ Noticeable changes in daily adaptive skills (i.e., eating, sleeping, hygiene, grooming)

- ❑ Increased or sudden isolation or neglect of vital relationships
- ❑ Agitated behavior (i.e., pacing, rapid speech, verbal threats, destroying property)
- ❑ Unpredictable or dramatic mood shifts
- ❑ Harmful or risky behavior directed toward self or others—including binge-drinking and drug use
- ❑ Tangential communication (i.e., incoherent, nonlinear speech that can be difficult to follow)
- ❑ Disclosure of recent trauma event—which may be causing physiological and/or emotional distress, or lack of distress that is of equal concern

Mental Health Ministers should recognize when a parishioner displays or describes witnessing these signs of a mental health crisis. It is important for Mental Health Ministers to maintain consistent and intentional responses to these situations. Of equal importance is the ability for a Mental Health Minister to assist others in recognizing a mental health crisis and how to respond. The following describes both helpful and unhelpful ways to respond to immediate crisis situations, which can be used by Mental Health Ministers, or be taught to other parish staff, ministers, volunteers, or, most importantly, concerned parishioners:

TIPS FOR A PRODUCTIVE RESPONSE	SIGNS OF A COUNTERPRODUCTIVE RESPONSE
☐ Remain calm: speak slowly, clearly, and confidently ☐ Be mindful of your own nervous behavior (i.e., leg shaking, pacing, abrupt movement) ☐ Use open body language ☐ Encourage the person in crisis to continue talking ☐ Avoid touching, shouting, rambling, and abrupt movements ☐ Listen to understand and paraphrase to reflect hearing ☐ Wait out (the panic, the screaming, etc.), but stay with—remain patient! ☐ Problem-solve in a collaborative manner—do not take away control and responsibility, but offer partnership ☐ Assure/repeat what the Minister will do next ☐ Encourage person to think of what or who has helped in the past to rely on known resources ☐ Be aware of personal safety,	☐ Intense questioning ☐ Judgmental, blaming, or sarcastic comments ☐ Making promises ☐ Jumping to conclusions ☐ Immediately over-empathizing can stunt the person's expression and providing a conclusion indicates doing things <i>for</i> the person, not <i>with</i> them ☐ Immediately problem-solving without all of the details can result in a longer or unnecessary process ☐ Displaying fear or passivity (i.e., dancing around the subject of suicide or other overt mental health concern) ☐ Leaving the person alone

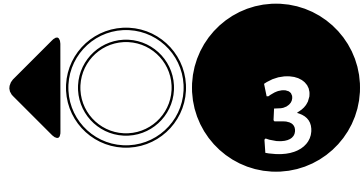
exits, and options for in-the-moment assistance (i.e., another person as a witness or a person who will call for resources/assistance as needed) ☐ Remove audience as needed	
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Any Mental Health Literacy training held for the Mental Health Ministry Team or other parish staff, volunteers, or parishioners should involve how to recognize mental health crisis situations and how to respond in the safest and most productive ways. Additionally, community mental health resources should be repeatedly displayed—in church bulletins, on the Mental Health Ministry portion of the parish website, etc.—and should include those resources that can provide immediate emergency assistance. This may include the local crisis intervention helpline, emergency services (to help de-escalate a dangerous situation, provide screening by trained professionals, and/or transport a person to a hospital as needed), or a list of community centers with mental health professionals on staff. Mental Health Ministers are not obligated to provide treatment for these mental health concerns, but Ministers should train to be as informed and prepared as possible for the multitude of situations they might encounter.

CHAPTER 2 ENRICHMENT ACTIVITY

For personal and/or Team reflection, examine the following questions:

1. What strengths, knowledge, and personal experience do I bring to the Ministry Team?
2. What are my "wounds" that I bear and share with others?
3. What disorders or conditions will be most challenging for me to witness or embrace?
4. As a group, discuss and identify those mental health needs within your means to address.



CHAPTER 3

INITIATING TIMELY REFERRAL TO PROFESSIONAL MENTAL HEALTH PROVIDERS

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Acknowledging the role of collaboration with professional mental health providers will be an essential part of successful Mental Health Ministry programs. Again, Mental Health Ministers should not be expected to *treat* mental health conditions. Collaborating with mental health professionals will encourage help-seeking behavior and will ensure that those seeking help have quality care and treatment, along with the companionship and support of the Mental Health Ministry Team. Ministers and mental health professionals share values that make collaboration a no-brainer: both ministers and mental health professionals act from the desire to serve and help others, both recognize the dignity of the human person, and both value the need for people who are suffering to find personal connection to others (Aten et al., 2013). Mental Health Ministry

Teams should recognize when and how to involve mental health professionals in the best interest of those in need.

Research has been conducted on the mental health-related topics that clergy, in particular, may encounter in their tenure. According to a survey conducted by Bledsoe et al. (2013), the most common mental health-related services clergy felt they were not able to provide included employment/unemployment assistance, LGBTQ concerns, substance abuse issues, stress and anger management, and legal issues (Aten et al., 2013). As mentioned in Chapter 2, there is great value in a Mental Health Ministry Team reflecting on what is within their scope of knowledge, experience, and skills. If the aforementioned list of mental health-related services align with some of the known needs of your parish community, begin finding legitimate resources and sources of information directly related to these topics. As with any parish program or ministry, acting from a place of humility is paramount. In the case of the Mental Health Ministry, humility looks like reaching out for wisdom and help when needed, and referring to professional mental health treatment providers in a timely manner. Ultimately, acting with humility can be life-saving.

At first, accompanying parish community members with mental health concerns may be straightforward and easily accomplished. These churchgoers may present with what are called “subclinical” mental health concerns, meaning that their identified symptoms or challenges do not meet criteria necessary to be formally diagnosed, and/or they may not be receiving any psychological aid or treatment. For these community members, simply having a conversation or prayer partner may be enough. It is important for Mental Health Ministry Teams to be mindful of complacency when

working with these “easy” parishioners. At the same time, Mental Health Ministers should recognize that some people are hesitant to seek and accept professional help due to the stigma behind mental health. As Mental Health Ministers, there will be a fine balance between encouraging and advocating for someone to seek professional help and allowing people to take steps toward treatment when they are ready. This is why continual dialogue with mental health professionals is necessary for consultation and connection of services. Should the “subclinical” concerns become more than temporary challenges, more severe, or have an effect on multiple areas of functioning, Mental Health Ministers should strongly encourage the involvement of professionals (Vermaas et al., 2017). Having preestablished relationships with local resources, support services, and mental health providers will make the referral process easier and streamlined.

You might be pondering, “But how are relationships with support services and mental health professionals even established?” Maybe your parish has no known local resources at the start. Or your Mental Health Ministry Team may have inherited a list of local mental health providers from your parish records that is two or three years, or even a decade, old. Creating and maintaining a record of current, legitimate, open mental health resources is paramount. As you look to refer parishioners to professional support, make sure that the professional support maintains a current license in the least, and is willing to take on a new client who may want spirituality incorporated into their treatment.

As a Team, you may consider creating a “Response Protocol” or a guideline of expectations for how to navigate a variety of situations, including but not limited to, immediate de-escalation or crisis

situations (as described in Chapter 2) and when/how to refer to mental health professionals. A common and consistent response from all members of the Mental Health Ministry Team, and perhaps extending to the ordained, other ministers, and parish staff, will build a stronger program. A shared response will ensure that the Mental Health Ministry is providing legitimate support, and, thus, all members of the team should acknowledge and agree to refer parishioners to other resources and mental health professionals when presenting with severe mental health concerns or are in crisis (Pillion et al., 2012).

Whether it is through the development of formalized protocols or guidelines, holding regular meetings to communicate concerns and seek consultation, or setting aside time to find resources that will meet parishioners at their level of comfort, there can be a variety of ways to support the mental health needs of the parish community's members. Incorporating regular trainings and conversations with mental health professionals will improve the knowledgebase and improve services of your parish's Mental Health Ministers. When scheduling trainings prove to be difficult, simply exposing Mental Health Ministers to local agencies, attending free or low-cost local events aimed to improve mental health services or targeting specific populations (i.e., Mental Health Run/Walk), and networking at as many opportunities as are available will increase the efficacy of the Mental Health Ministry Team. In the end, these local agencies and events can be shared with the parish community as resources, either directly or indirectly. That is, Mental Health Ministers can invite parishioners to local mental health-related events, go to a resource center or agency with a churchgoer, or make calls and appointments with the person in need as a direct service. In a more passive manner,

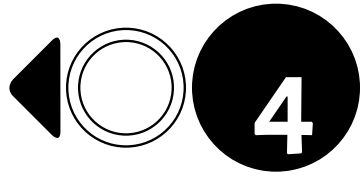
resources and steps for help-seeking can be posted on the parish website to capture those who may not be ready to directly engage with Ministers but who desire more information. Ultimately, discussing as a Mental Health Ministry Team what you yourself would want if seeking help—an active companion on the journey, help with referral and seeking treatment, or more passive support—will inform how your Team can proceed to serve the mental health needs of your parish.

CHAPTER 3 ENRICHMENT ACTIVITY

For personal and/or Team reflection, examine the following questions:

1. What mental health aspects or issues have you or your parish encountered? Are there common themes of mental health challenges your parishioners face?
2. Considering the population you will serve. What are the “pros and cons” for the following options:
 - a. Creating guidelines or a formal protocol for referral to mental health professionals
 - b. Holding regular consultation meetings with mental health professionals at the table (to discuss concerns, present questions, learn more, etc.)
 - c. Having mental health professionals who are open to “on-the-spot” referrals
3. As a Mental Health Ministry Team (or individual), take a moment to dialogue: what connections to mental health

professionals, groups, or agencies do you have that can serve as resources?



CHAPTER 4

DIFFERENTIATING MENTAL HEALTH MINISTRY FROM MENTAL HEALTH TREATMENT

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As detailed in Chapter 1, Mental Health Literacy involves the recognition of the signs and symptoms of mental health conditions, as well as knowing when to gather more information and when to seek professional help. Mental Health Ministers must be willing to involve support, information, and guidance from outside sources. As much as the Ministry involves having background knowledge of mental health conditions, in the end, the Mental Health Ministry is distinct from mental health *treatment*. The focus of the Mental Health Ministry, as with any ministry, should be to journey with others as they experience God and all His works, and to encounter the Trinity in others. Pope Francis has spoken and written about our call as Catholics and Christians to *encounter* or meet others, especially those who are most in need, with grace through Christ. There is a misperception that mental health problems should be

treated in secrecy, which subsequently increases the sense of isolation and despair. Ministry has the power to pull people in. As Pope Francis puts it, we are called to go out into the “periphery” and encounter one another. Rarely does mental health treatment trek to these ends. Likewise, rarely does professional treatment ask the question, “Where is God present in this?” or “Where is God in the suffering?” Chapter 8 explores some theological considerations behind the Mental Health Ministry, but as we continue to distinguish ministry from treatment, there is no doubt that the distinction of ministry is that it exists as faith-based and God-centered without direct implementation of psychological interventions.

The Mental Health Ministry should be considered a part of the support system necessary for successful professional treatment. A person under the treatment of a mental health professional should be encouraged to find a renewed sense of meaning and purpose, feel grounded in faith or other spiritual practice, and increase social connection as needed—all of which can be found through an active and caring Mental Health Ministry program. Transformation and healing can be a spiritual and ministerial philosophy behind the program. However, to expect that treatment of mental health disorders happens only at a parish level—again, treating mental health problems in secrecy—is not embracing of the community and the gifts and talents that others may have with addressing mental health issues from an evidence-based approach. Again, we are reminded that we must encounter people as they are, at whatever stage of their mental health journey they may be.

From a psychological perspective, a mental health diagnosis will manifest itself in a pervasive manner, affecting multiple areas of

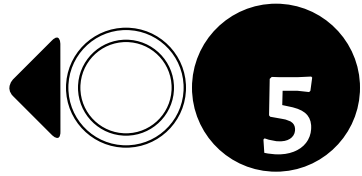
living (i.e., occupational, financial, interpersonal, spiritual, etc.). Given this, sound mental health treatment may involve a number of professionals and support collaborating—a psychologist or therapist to guide the treatment, a psychiatrist or primary care physician to monitor medication management or any other medical concerns, family and caretakers to provide continual support in the home, and other social supports—such as Mental Health Ministry programs—to share in the everyday journey. Mental Health Ministers provide spiritual and social support that mental health professionals cannot provide. Treatment can involve theoretical approaches that allow space for making meaning and finding purpose, but the ultimate goal is to address the symptoms and treat the disorder. Ministry, in contrast, has the distinct pleasure of incorporating the all-important existential questions to seek God’s will and presence during the hardship.

Across both Mental Health Ministry and mental health treatment, communication and collaboration are necessary. Mental Health Ministry Teams and treatment providers must agree to acknowledge that there are mental, emotional, physical, behavioral, and spiritual components to mental health. Finding balance and holistic wellness that addresses all of these areas will not be possible without both ministry and treatment coexisting. Treatment may have its limitations—existing in a system of managed care and insurance barriers, not having the freedom to intimately involve faith and religion—but there are methods behind the interventions. Similarly, Mental Health Ministry will have its limitations, but its maintenance as God-centered will undoubtedly contribute to healing and wellness.

CHAPTER 4 ENRICHMENT ACTIVITY

For personal and/or Team reflection, examine the following questions:

1. How have you been nourished by encountering Christ in others through the darkest, most difficult times of your faith journey?
2. Mental Health Ministers provide a spiritual and social support that mental health professionals cannot provide due to therapeutic relationship limitations. Imagine the mental health ministerial relationship—how can you provide spiritual and social support? What questions, comforts, and challenges can you offer to others?



CHAPTER 5

LEGAL AND ETHICAL ISSUES IN MENTAL HEALTH MINISTRY

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WILLMERDINGER

General Ethical and Legal Considerations

As with any ministry or church program, there are ethical considerations that each lay minister or volunteer will be expected to know and understand. A diocese should have *Standards of Conduct* or *Ethical Standards* that outline expectations for all clergy, pastoral counselors, volunteers, and lay ministers within that diocese. Additionally, dioceses should have a clearly defined scope of duty for lay ministers and volunteers. It is important that anyone who comes forward with a desire to serve on a Mental Health Ministry Team consider a variety of legal and ethical issues that are not only guided by the principles of ministry or the diocese *Ethical Standards*, but by the sensitive nature of interacting with a person experiencing mental health afflictions. Those Mental Health Ministers who hold active professional licenses or credentials in the mental health field should consider the legal and ethical expectations set by their licensing

agency. Although these ministers are volunteers and not formally working in their capacity as a mental health professional, there should be a personal understanding of any moral obligations (or state/licensing agency ethical and legal obligations) that may apply to a variety of situations. Indeed, it is our recommendation that health and mental health practitioners involved in the Mental Health Ministry assume roles that support the ministry directly (i.e., organizing, leadership, facilitating large group presentations) but do not necessarily involve individual accompaniment for parishioners. This practice helps limit the potential for dual relationships and confusion of the nature of the lay ministerial relationship on the part of the parishioner. Whether a mental health professional by trade or not, Mental Health Ministers should always maintain appropriate ministerial boundaries and adhere to the scope of duty defined by their diocese.

Given the depth and breadth of information provided in our playbook, the line between Mental Health Minister and mental health professional can seem convoluted. It might feel like there is so much for a Minister to know, consider, and do. However, we must always keep the heart of ministry and the function or purpose of ministry in perspective. While engaging in a ministerial relationship with someone is a personal experience, because of the intimacy of knowing someone's mental health challenges and suffering, it can easily become an enmeshed helping relationship that far exceeds what is appropriate for ministry. The Mental Health Ministry Team should set its own list of expected behavior for its ministers when interacting with the congregation. For example, how will boundaries and limits be communicated? While we have emphasized that Mental Health Ministers should be invested and knowledgeable

companions who accompany others in their journey, it is important to be explicit about when and where Mental Health Ministers can engage with the congregation. For instance, we have suggested that Mental Health Ministers offer to accompany parishioners to community-based support groups or other events that are relevant to mental health support. However, this is within the scope of encountering the congregation on their path to help-seeking. We are not suggesting that Mental Health Ministers extend themselves to all moments of mental health treatment developments. We certainly would not want Mental Health Ministers to feel the need to be “on call” or responsible for immediate communication and companionship. Mental Health Ministers will be in positions to serve, but service must have boundaries. As Saint Paul wrote, “Indeed, I worked harder than any of them—though it was not I, but the grace of God that is with me” (1 Corinthians 15:10). That is, the boundaries for serving can be further clarified—it is not the Mental Health Minister at work and providing the grace in this ministry; it is ultimately the work of the Trinity, and so the ministerial boundary is simple—do what is humanly reasonable, but allow space for the Trinity to do what it does best.

Boundaries with Minors

A parish’s Mental Health Ministry program will need to be firm and clear on its purpose/mission, scope of work, intention, and boundaries or limitations. Mental Health Ministry is not mental health *treatment*; this cannot be emphasized enough. While that limitation is clear, in practice setting boundaries can be far more challenging, especially when working with the mental health issues

of minors. Pope John Paul II was known for his focus on transforming the hearts of the youth through concerted ministry efforts. He is credited with saying that it is a “vocation to love that naturally allows us to draw close to the young.” Some Mental Health Ministers may find setting boundaries with minors to be especially challenging, as encountering young people with any degree of mental health challenges can spark a great desire to help. In the end, all Ministers should be able to manage their emotional reactions and boundaries with any parishioner with whom they may potentially work. Diocesan *Standards of Conduct* or other processes for orienting volunteers and ministers to work with youth will always guide the boundaries set in ministry, especially when working with minors.

Multicultural Considerations

There are many reactions and various levels of receptivity to mental health issues based on beliefs, values, and cultures that vary from person to person, family to family, community to community, and so on. Taking a personal inventory of the messages you received throughout your lifetime about mental health, or having serious problems and seeking help, will give you an indication of how perceptions are formed. Your own impressions of mental health may differ greatly from someone with whom you would consider yourself close. Building your self-awareness about your reactions, thoughts, and beliefs about various aspects of mental health, including an honest acceptance of what aspects you feel most drawn to and what aspects you are most hesitant to encounter, will be a necessary part of building a strong Mental Health Ministry Team. Likewise,

communicating these reactions to those on the Mental Health Ministry Team and continuously opening up about your experience in ministry will help ensure that fulfilling the mission of the Mental Health Ministry Team is done with great intention and care.

Just as your own impressions about mental health may have been influenced by culture, so too do those whom the Mental Health Ministry Team will serve also come with perceptions about mental health that have been formed by a multitude of interactions and messages received. There are some generally known culturally influenced attitudes about mental health and related help-seeking behavior. As mentioned, when interviewed, those identifying with certain cultures—African Americans and Asian Americans, for example—reportedly prefer to seek support for mental health issues from clergy rather than from medical professionals (Vermaas et al., 2017). Likewise, these populations, along with Latin and Hispanic cultures, tend to mistrust systems of care related to mental health. Some folks, by heritage or lifestyle, prefer natural and holistic approaches to all health issues. It is important to acknowledge how difficult help-seeking for mental health concerns can be for people in general, but especially for those whose culture may stigmatize mental health and its treatment.

Gender and LGBT-related concerns can also impact how parishioners respond to Mental Health Ministry. Definitions of masculinity and gender roles have long been inspected and debated throughout many religions and cultures. There are certainly many within the LGBT community who have their own personal experiences of shame, guilt, and trauma when chastised by members of the parish or even members of their own family who have remained staunch in religiosity without any acknowledgment of the

compassionate love of Christ we are all called to give. There is a space within the Mental Health Ministry for those who have questions, who seek understanding, and who are defining their identity or discovering the identity of others and are hoping for their identity of Christian to remain constant.

Responsible Caretaking & Self-Care

The Mental Health Ministry can demand that many “considerations” be made—ethical, legal, multicultural, and more. Because it will take great effort to maintain all of these considerations, Mental Health Ministry Teams have an obligation for consultation with mental health professionals, collaboration with others in the Mental Health Ministry, and continued education out of respect for the dignity of those we serve. Through humble admission that Mental Health Ministers do not need to know everything about the world of mental health, we can offer a safe space to learn and grow and experience together. The most responsible caretaking involves responsible accompaniment.

As this chapter and Chapter 13 emphasize, boundaries will ensure that proper ministerial relationships exist. However, boundaries are equally important for the balance they can bring to Mental Health Ministers on a personal level. Remaining mindful of our own personal well-being as we serve and accompany those who suffer from terrible and sometimes traumatic circumstances and conditions will keep us from experiencing our own forms of helplessness, depression, and burnout. It is easy to become entwined in the lives—the ups and downs of treatment, recovery and relapse, progress and backslides—of those suffering from mental health

challenges. We may think that answering a call to serve as Mental Health Ministers means sacrificing our own selves so that others can begin to find the light, comfort, and companionship they seek. For many, serving as a Mental Health Minister will be a volunteer position—on top of the demands of our occupation, family life, and other relationships and responsibilities. Entering into a ministerial relationship can become yet another caretaking role for those already providing so much support to others. Be mindful of this before becoming involved in the Mental Health Ministry program, and focus on balance, self-care, and setting boundaries to serve others responsibly.

Private vs. Confidential Communication and Mandated Reporting

Research indicates that people seek support from clergy due to the premise of confidentiality (Vermaas et al., 2017). While this research reviewed those in a formal position at the parish (“clergy”), it can follow that those who access the Mental Health Ministry program will presume a level of safety and desire for confidentiality. *To clarify, there is a distinction between confidential communication and private communication.* Private communication refers to information that is not typically shared in public, but is more for the individual or for those closest to the individual to know or witness. Confidential communication usually means that information is personal, and permission must be given for that information to be shared. Confidential communication is usually protected by law; private communication may not be clearly protected. *In nearly all situations of the Mental Health Ministry,*

communication between parishioners and ministers will be considered private, not confidential.

It should be clarified from the beginning of the ministerial relationship which communication may be considered confidential and which disclosures will remain private, with both confidentiality and privacy clearly defined. Additionally, Mental Health Ministers should explain their scope—their knowledge and abilities/services (i.e., listening, prayer, accompaniment)—that they can provide. We are being mindful of these steps to emphasize the responsible services given by Mental Health Ministers. As we have covered, people who access the Mental Health Ministry may assume that they can receive *treatment* from the parish programs or may disclose intimate details of their mental health challenges believing these will be held in confidence. The Mental Health Ministry is not *treatment*. However, to provide a safe space where all are welcome and able to find connections, Mental Health Ministers can assure the congregation that they will be cared for. While clergy (i.e., priests, deacons) may be able to give more clarity around private vs. confidential communications, in the end, please remember that Mental Health Ministers should never mislead.

Mandated Reporting

State statutes defining those to be considered mandated reporters of child abuse and neglect—meaning those with a legal obligation to report any time they suspect child abuse may have occurred historically or is currently occurring—vary from state to state. The laws return to the concept of privileged versus confidential communication in the context of confession. First, it is important to

define clergy and their role. In California, “clergy” is defined as a priest or “similar functionary of a church” (California Penal Code § 11165.7(a)(32)-(33)). Second, Mental Health Ministry Teams should be attentive to when reporting is mandatory and when it is not. Taking California as the example once more, clergy who reasonably suspect child abuse or neglect as a direct result of “penitential communication” (i.e., confession), which is communicated in confidence, do NOT have to report (Cal. Penal Code § 11166(d)). However, when clergy are “acting in some other capacity that would otherwise make the clergy member a mandated reporter” (i.e., outside confidential communication during confession), they must report suspicion of child abuse or neglect. While volunteers and ministers do not hold the title of “clergy,” nor carry all responsibilities and functions of a priest, diocesan Standards of Conduct or similar guidelines may further define the expectations of ministers when it comes to mandated reporting. If it is this clear by state law when a priest is to report suspected child abuse—any time the information is received outside of the confidential communication of confession—then it is likely that whenever a Mental Health Minister suspects child abuse or neglect is occurring or has occurred, they will need to follow the expectation to report this suspicion to local law enforcement or child welfare agencies.

Survivors of Clergy Sexual Misconduct

Dioceses across the United States and in other parts of the world have created the infrastructure to respond to survivors of clergy sexual misconduct, their loved ones, and those clergy involved in sexual misconduct. It is necessary that Mental Health Ministers

know the expectations of their diocese when it comes to working with those who disclose being survivors of or having knowledge of acts of sexual misconduct by clergy. Here we will refer to “sexual misconduct” as terminology to encompass sexual harassment, sexual exploitation, and sexual abuse. Your diocese may clearly define terminology (i.e., sexual misconduct) for you to consider and use when working with others in your capacity as a Mental Health Minister.

The United States Conference of Catholic Bishops has recently revised its *Charter for the Protection of Children and Young People* (USCCB, 2018) to outline “practical and pastoral steps” focusing on the need to protect the youth of the parish, as well as to assist in the healing of those affected by clergy sexual misconduct. One such step is to create a safe environment. All clergy, ministers, volunteers, and anyone working in a role of service in a parish must consider the *Standards of Conduct* set by the diocese and clarified at the individual parish level. Mental Health Ministers can assist by reminding others to keep their communication open and always create a safe space for dialogue and worship. The Mental Health Ministry Team can also organize an educational series to help youth of all ages learn about personal safety, which the children can apply both at the church and outside of the church. Dialogue as a team and as a parish for any steps you may need to take to protect the young people while they access parish services.

For those who have disclosed being survivors or otherwise impacted by clergy sexual misconduct, a focus on healing and reconciliation should be maintained (USCCB, 2018). When responding to a person disclosing, they are a survivor of sexual

misconduct, or a person whose loved one is a survivor, take the following into consideration:

- As mentioned in Chapter 2, remain calm and refrain from expressing your immediate feelings or reactions (i.e., shock, rage) so as to avoid influencing the survivor's process.
- Allow the survivor to express their range of emotions (i.e., anger, sadness, fear).
- Empower the individual to take action as needed—explain how reporting can be managed if the incident of misconduct has not already been reported, encourage the survivor to seek support from mental health professionals and/or medical care as necessary. It is important for the survivor to hear and be acknowledged for what is in their control.
- Encourage the survivor (and loved ones) to allow authorities, including those at the diocese, to respond.
- If the survivor of sexual misconduct by the clergy is currently under the age of 18, mandated reporting must be followed and legal guardians must become involved.

The Mental Health Ministry Team should endorse and help build the strength and resilience of all of their parishioners by encouraging help-seeking behavior and wellness always, but most especially in the case of survivors of clergy sexual misconduct.

A Mental Health Minister who encounters a survivor of clergy sexual misconduct will need to recall the importance of referral. Referral, and sometimes accompaniment with the referral, will need to be made to medical care, diocesan resources (i.e., Diocesan Victims Assistance Coordinator), and mental health professionals as indicated. Respect for the individual and loved ones should also

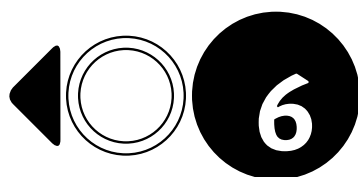
remain a priority. The survivor and their loved ones may have lived years after the incident before allowing others close enough to know of their experience. Many who have experienced such a violation have questions, insecurity, and damaging perspectives of religiosity and faith. These boundaries and wounds must be respected as unique to each survivor and/or loved one. The process of recovering and dwelling as a survivor may be tough to understand but will most desperately require sensitive accompaniment. Mental Health Ministers ought to continue with compassion and a constant sense of welcome, ensuring that the parish is a space where healing and reconciliation can take place.

CHAPTER 5 ENRICHMENT ACTIVITY

For personal and/or Team reflection, examine the following questions:

1. Take time to review the Standards of Conduct or other publications specifying the formal expectations for the behavior of all ministers, volunteers, and the like within your diocese.
2. What cultural and/or age-relevant considerations do you foresee as being most sensitive and pertinent in your parish?
3. Rehearse the following (good exercise to do in pairs):
 - a. Explain the purpose of the Mental Health Ministry program.
 - b. Describe the scope/role of a Mental Health Minister, including limitations and boundaries.

- c. Elaborate on the difference between private and confidential communication.



CHAPTER 6

SPECIALIZED MENTAL HEALTH MINISTRIES

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All of the considerations, suggestions, and possibilities explained in this playbook thus far may make the work of a Mental Health Ministry program seem daunting. Let us not lose hope. The Mental Health Ministry has been successfully implemented in many parishes, and the benefits have been proven. In particular, the Mental Health Ministry has been shown to effectively support parish community members with mood disorders (i.e., anxiety, depression) (Matsuzaka et al., 2017, p. 225). Anecdotally, people often turn to God, faith, or religious traditions when they experience suffering, restlessness, disconnection, or longing. Thinking back to the common signs of mental illness outlined in Chapter 1, some of these may be the most common reasons for Mental Health Ministry services. Lay ministers can be useful in assisting with the reduction of depressive symptoms, such as sadness, hopelessness, and finding a sense of worth. Mental Health Ministers can persuade those with anxiety to identify what is within their control and reduce anxious feelings through centering prayer or spending time in silent

reflection. While it may seem like there are many steps and things to consider, the Mental Health Ministry can help transform lives, even the lives of those with severe or chronic mental illnesses.

The Mental Health Ministry Team should collaborate with other health and social ministries within the parish to create an inclusive and safe community for those experiencing any level of emotional distress. The overlapping purpose of these ministries is to connect to the parishioners, encountering others as they are and promoting their well-being. By working with other existing ministries, Mental Health Ministers can dive into the service of those with chronic mental health problems. Ideas include sponsoring care packages for those whose loved ones may be going through a particularly difficult time, sharing a rotating visiting schedule for those hospitalized or homebound due to mental health issues, and holding prayer groups or joint-sponsoring devotions. The potential for this collaboration is limited only by the imagination.

Considerations for Those with Severe Mental Illness

Those with major mental health problems (i.e., psychosis, endorsing high suicidality, severe developmental or behavioral concerns) should seek treatment from a mental health professional first and foremost. If it is identified that the severity of the mental health challenge is beyond the scope of what the Mental Health Ministry Team can address, then referral is the highest priority. Once again, we reiterate the definition of Mental Health Literacy, as it includes the recognition and knowledge of a variety of mental health conditions, as well as the awareness of supports available and the ability to seek guidance as needed. In the case of more serious

mental health concerns, Ministers can provide support in a mixture of ways:

- Offer a comforting, nonjudgmental, and validating space where those with severe challenges and/or their loved ones can feel safe, heard, and supported.
- Become educated (by credible sources of course!) and show an interest in their experience of the mental health problem.
- Bring them in and include those with severe or chronic mental illness and/or their loved ones.
- What parts of parish programs or events must be adjusted to include those whose mental health symptoms may be exacerbated during the program or event? Is accessing the liturgy a problem because of the severity of their symptoms? What can be accommodated?
- Promote and accompany (if allowed) parishioners to local, professionally led support groups.
- Ask the person with severe or chronic mental illness and/or their loved one what they need, what would best support them, and go from there.
- Pray, pray, and pray some more!

There is a place and a purpose for the Mental Health Ministry in the support and betterment of the lives of those experiencing severe or chronic mental health challenges and their loved ones. Our parishes are certainly one of those places. Many parishioners suffering from severe mental illness are or have been affected by homeless and/or housing insecurity. Also, individuals with severe mental illness who are homeless may seek refuge on the parish

campus and in Mass. In these situations, the Mental Ministry Team should consider the following:

- How do we encounter the face of Christ in these individuals?
- Are these spaces in our parish campus to potentially shelter homeless parishioners with severe mental illness?
- How might we design safe shelter spaces for these individuals?
- Are there resource providers in our community that we might partner with to support these individuals?
- If not, how might we muster other resources and volunteers in our own parish communities to address these needs?

Consideration for Those with Addiction or Substance Use Disorders

Substance use and abuse issues can be difficult to navigate from any perspective. There are many names and phrases—substance abuse, drug or alcohol addiction, chemical dependency, or alcoholism (when specifically dealing with alcohol)—that you may have heard as easily interchangeable terms to describe someone’s excessive and patterned use of drugs or alcohol even when faced by significant life problems related to their use. According to the 2017 *National Survey on Drug Use and Health* sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2017 some 19.7 million Americans (ages 12 and older) had a substance use disorder, including 14.5 million Americans who struggled with an alcohol use disorder in particular. The same survey found that 7.6 million Americans (ages 12 to 25) had experienced a major depressive episode in 2017. While the

experience of a major depressive episode is a great concern and should receive careful attention, these numbers are shared to point out that while many presume mental health problems are synonymous with depression and anxiety, something like a substance use disorder can be ignored or hidden when, clearly, there are many who suffer. It can be argued that many who experience mental health problems may begin to experience problematic and dangerous self-medication (numbing, escaping, or attempting to minimize mental illness symptoms) with substances. Likewise, many with substance use challenges may come to experience substance-induced depression and anxiety, or myriad other mental health concerns in conjunction with their substance abuse.

There is much information available on the internet regarding substance abuse and chemical dependence. Of these many pearls of wisdom, Mental Health Ministry programs should consider that substance abuse often exists as a “family problem” that affects all members of the family, not just the person who has the substance abuse disorder. Addiction can often feel unpredictable—behavioral patterns may exist, but the duration or intensity can vary greatly. Because of this, along with the constant fluctuation in the person with substance use difficulties being unreliable or failing to carry through with responsibilities, those surrounding the person with substance use problems are often left feeling overburdened, insecure, under-valued, and exhausted. Reaching out to the family, encouraging them to practice self-care and self-love, and showing them compassion will be essential functions of the Mental Health Ministry Team.

Many of those with a substance use disorder and their families find success and support through groups modeled after a 12-Step

Program, such as Narcotics Anonymous, Alcoholics Anonymous, or Al-Anon Family Groups. These 12-Step Programs commonly endorse an individual acknowledging that they are powerless to alcohol or substance and should surrender to a “Higher Power.” For those connected to a faith tradition, this Higher Power may easily become God in all His omnipotence. While some acknowledge God, in the end, Mental Health Ministers should embrace that the concept of “God” or a Higher Power that is seeker sensitive. Other processes in 12-Step Programs include self-reflection and acceptance of what actions have been done through the experience of addiction, as well as making amends and seeking forgiveness for many wrongs and hurts. The Mental Health Ministry Team can clearly link to these processes. Mental Health Ministers can listen genuinely to others’ experience without judgment, support the reflection process, validate the difficulty in acknowledging and allowing God to be fully in control, and always promote health and safety first and foremost. Many 12-Step Programs begin with a wholehearted acknowledgement of the addict’s powerlessness to the substance or compulsive behavior, and the humility to surrender to the will of a Higher Power. Strip away all titles, diagnoses, and labels and this path simply sounds like a person following the footsteps of God.

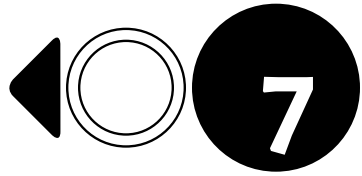
CHAPTER 6 ENRICHMENT ACTIVITY

For personal and/or Team reflection, examine the following questions:

1. Take a moment to research: What local support groups, mental health agency events, or 12-Step meetings exist in

your neighborhood as potential options for your parishioners?

2. Discuss honestly: What parts of parish programs or events must be adjusted to include those whose mental health symptoms may be exacerbated during the program or event? Is accessing the liturgy a problem because of the severity of their symptoms? What can be accommodated?
3. How do we encounter the face of Christ in others who struggle with severe mental illness, homelessness and/or substance abuse?



CHAPTER 7

A MINISTRY OF ACCOMPANIMENT

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There are many Christians who endorse and live by the words, “When in doubt, pray it out.” At this point in our playbook, the Mental Health Ministry may seem “as clear as mud.” And so, we fall back on the foundations and core teachings of our Church, found in Scripture, the *Catechism of the Catholic Church*, writings of Church leaders such as Pope Francis, and, of course, the saints, our role models in faith. Entrusting that God is at work in the lives of the parishioners we serve and seeking the understanding necessary to journey with those suffering from mental illness will take active prayer. In this chapter, we look at the simplest and most basic ways to accompany and provide open programming for Mental Health Ministry. What does it mean to be on this mission? To paraphrase Pope Francis, at the center of being a missionary disciple, including a Mental Health Minister, is being engaged in *accompaniment*. This means being involved in a spiritual relationship with someone so that we reciprocally reflect the love of Jesus to each other. This is the

foundation to the notion of an inclusive parish community. As we encounter each other in the love of Christ, we reflect that love upon each other. When we connect with parishioners seeking the support of the Mental Health Ministry, we engage in accompaniment.

Importance of Scripture

First, we look to Scripture for wisdom and to help make sense of the difficulties of mental health challenges. There are many themes found in the book of Psalms, but the idea of man being less than or helpless without the power, grace, love, and guidance of God is clear and can be a helpful anchor when working in the Mental Health Ministry. Psalms 42 and 43 describe the soul as distressed, acknowledge the human feelings of isolation and depression, and end in seeking and calling upon God, putting hope in God for safety and comfort. Many who regularly experience the challenges of mental illness can identify with the desperation expressed in these Psalms. Has God forgotten them? Is the oppression and burden of mental health issues a message from God? The anguish of living with mental health disorders is indescribable. As Mental Health Ministers, we cannot promise an immediate erasure of the misery. We can, however, remind others to hope in God and never lose sight of God's constant presence, just as the Psalms remind us.

The epistles of Saint Paul are helpful, straightforward challenges for ministers to live and serve with great love, and reminders for parishioners experiencing mental health difficulties to maintain faith even under the most desperate challenges. In the first epistle of Paul to Timothy, we are summoned to "fight the good fight of faith" (1 Timothy 6:12). This rally call can be a good reminder to those

accessing Mental Health Ministry services, as well as those working on the Team—life brings many battles, but we are all armed with faith. In Romans 5, Saint Paul reminds us that because of our faith, we are promised the graces of peace and hope through any difficulty. “Suffering produces endurance, and endurance produces character, and character produces hope, and hope does not disappoint us, because God’s love has been poured into our hearts” (Romans 5:3–5). It is difficult to make sense of suffering. For those living with the despair that is associated with mental health afflictions, being reminded to have hope and feel God’s love is easier said than done. For this reason, Mental Health Ministers cannot just throw out these Scripture passages without being living examples of what it means to have hope and what it looks like to be God’s love for others. As Mental Health Ministers, we use faith and grace to receive others with gentleness and “bear one another’s burdens” in a way that defeats the isolation of mental illness and strengthens faith—our own and the faith of those whom we serve (Galatians 6:2).

Worship and Liturgies

To show that Mental Health Ministry is an embraced and incorporated service to others, church services and liturgies should include mention of mental health, not just as a necessary “checklist” item that we must make sure we mention, but as a truly integrated concept that contributes to the Church’s diversity and universal identity. In Mass, homilies and intercessions can begin to acknowledge the realities of mental health issues. When we pray for and serve the sick, do we believe this applies only to physical ailments? To go even further, an annual Mass celebrating and

dedicated to people with mental health challenges can be held. We should recognize that mental health is a part of holistic wellness and we should all be praying for the wellness of our brothers and sisters.

Service and the Dignity of the Human Person

Looking at the *Catechism of the Catholic Church*, we are reminded that serving in ministry is to support “the common good,” both locally and universally. Outreach and companionship with those suffering in the darkness of mental health issues is certainly a fulfillment of our social responsibility to support the human person and the social conditions of others. When we consider that as members of the Catholic Church we join in the universal mission to support what is necessary for human life, which includes the aspect of *health*, we know that providing a Mental *Health* Ministry is of great importance.

As we follow the Great Commandment to love others, we join in solidarity with the conditions in which others are found. Everyone is invited and welcome to “come as you are,” and if they come with debilitating depression, history of trauma, life adjustments that rock their core being, or deep anxieties, Mental Health Ministers will be present to serve. To expand on the acknowledgement of the “common good,” the *Catechism of the Catholic Church* explains social justice and the dignity of the human person. Here, the Catechism explains that we can be a “neighbor to others and actively [serve]” others. Connecting to another human person can be all that is needed for ministry to succeed. While Mental Health Ministry Teams have many things to consider in order to be responsible and appropriate ministers, the most basic understanding is the need to

embrace and support the whole person, including their psychological dignity.

Devotions to the Saints

While there are many forms of prayer, devotional practices are a unique method to enhance our spiritual life and remember and accompany those we serve in the Mental Health Ministry. We have just reviewed Scripture that anchors the idea that we rely on faith to carry us through—faith to guide us as we serve those fighting through mental health issues and faith for those who seek the graces of love, peace, and hope through their mental health challenges. Devotions to the saints enrich our faith and spirituality.

It is easy to forget the powerful role models we have in the saints. We make modern-day saints and idols of leaders, public figures, or “influencers” who may bring goodness in the midst of the chaos, hustle, and nonsensical cruelties of our current world. While this may give us temporary relief from the trials of everyday life, the Mental Health Ministry includes the challenge to ask the toughest question of those who have abstract ailments—amid the pangs of living with mental health disorders, where is God? The answer can only be revealed through faith and prayer. Sitting with prayerful attention to the saints, whomever we direct our devotions to, will inspire productive accompaniment.

Prayerful times of devotion are simple ways to implement Mental Health Ministry services and can be accessible to everyone, even those who cannot physically reach the parish grounds. If there is anywhere to start with programming for a Mental Health Ministry Team, we suggest that scheduled devotions—offering Masses with

special intentions for parishioners in need or with the intention of those experiencing mental health difficulties, novenas, or prayer times—exposing all parishioners to Mental Health Ministry is a strong way to start.

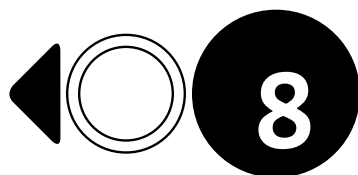
The patron saint of mental and neurological disorders is Saint Dymphna, whose feast day is honored on May 15. A martyr, the story of Saint Dymphna is one of bold faith and unending courage, fitting graces to seek for those who regularly battle mental health issues. Mental Health Ministry Teams can consider distributing Saint Dymphna prayer cards as an initial outreach to promote the ministry. Another great woman of faith, Saint Monica of Hippo remained steadfast in her faith as she became a great example and witness of God’s love and omnipotence. Saint Monica is revered as the patron saint of abuse victims and is often remembered as someone who constantly prayed for those around her, even her enemies. Petitions and devotions to these great saints can focus on specific mental health disorders or aspects, or may be more generally intended for any emotional and psychological affliction. Prayerful intention can be a steady foundation for the Mental Health Ministry.

CHAPTER 7 ENRICHMENT ACTIVITY

For personal and/or Team reflection, examine the following questions:

1. What Scripture passages have been a source of comfort for you? What Scripture can the Mental Health Ministry Team adopt as their “power verse?”

2. A great resource to consider creating and providing for those accessing Mental Health Ministry services is a list of Bible verses that are relevant for different mental health aspects. Many online resources exist (as well as an example in the Appendix), but making a list unique to your parish population is personal. Take some time to identify Scripture and associated mental health themes that would be beneficial for your parishioners.
3. Review the devotions to the saints in the appendices. Which devotions resonate with you? Reflect on why that might be.



CHAPTER 8

MAKING IT HAPPEN: IMPLEMENTING THE MINISTRY

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By now, our hope is that you have learned, absorbed, and reflected on many aspects of mental health as it is folded into a unique ministry to serve the Church. However, many of you may have been itching to find out just exactly how all of this comes together. As with the rest of this playbook, the following is based on research and lived experience, but is in no way a perfect recipe for a successful Mental Health Ministry program. Keep in mind that our suggested implementation plan should be adapted to fit the needs of your specific diocese and the parishes it serves and in consideration of your resources and local community context. Five of the six implementation steps outlined next are from *Creating Caring Congregations*, a five-step program developed by the Reverend Susan Gregg-Schroeder (n.d.), an ordained Methodist minister and early pioneer in the Mental Health Ministry. These five steps are: 1) Education, 2) Covenant, 3) Welcome, 4) Support, and 5) Advocacy. We have added a sixth step, 6) Evaluation, to provide guidance on

how ministry teams can assess the depth and impact of implementation of a Mental Health Ministry program. All in all, keep in mind the broad concept that in order to build a successful Mental Health Ministry, there must be Awareness, Acceptance, and Accompaniment.

Implementation in Six Steps

STEP 1: EDUCATION

All clergy, parish staff, ministers, and the Mental Health Ministry Team should meet Mental Health Literacy standards so that no matter who comes in contact with a person struggling with a mental health concern, the need for support can be identified in a timely manner. Because Mental Health Literacy begins with recognizing disorders and signs of psychological distress, and having knowledge about the risk factors, causes, and interventions for a variety of mental health conditions, it makes sense to begin the implementation of the Mental Health Ministry with education. Education should come from valid and credible sources: surveys, interviews, and dialogue with mental health professionals in your congregation. Identify and visit local agencies or psychiatric hospitals to learn about their programs. Read and share information. When turning to print material (i.e., books) or internet articles, make sure that the credentials and background of the author are trustworthy. Many renowned universities and government agencies publish scientifically supported information that can be useful to the Mental Health Ministry Team and congregation. There are many small ways to obtain dependable, and often free, education material.

Of course, if it is within the means of your parish, accessing conferences, workshops, or webinars for education opportunities could also be an option. Speakers and experts can be invited in to educate the Mental Health Ministers, parish staff and clergy, and members of the congregation, depending on the topic. There should be a distinction, however, between education provided to Mental Health Ministers and education provided to the general parish community, given that Mental Health Ministers should be held to higher standards of foundational knowledge. Education for the congregation can be provided through Mental Health Ministry events and resources (including support groups and community-based services) and passive education material (i.e., pamphlets available in the parish office, comprehensive electronic resources linked to parish websites). Finally, if the parish hosts health and wellness events, the Mental Health Ministry should certainly be included and allowed to provide education in addition to promotion of their program.

While education is being presented as the “first step” in forming a Mental Health Ministry program, education should always be a part of the ministry. Just as mental health professionals must stay up-to-date on the latest research and progressive considerations, so too Mental Health Ministers will be expected to continually seek out opportunities for sound learning and useful dialogue. Working with other parishes is discussed in the final chapter, but sharing wisdom and best practices with each other—across ministries and churches—will be an invaluable way to learn and grow your parish’s Mental Health Ministry program.

STEP 2: COVENANT

Any ministry program will involve commitment—commitment of time, energy, and resources. Additionally, any ministry program will have a basic agreement to serve as we are called, to share the Gospel message, and to act as Christ showed us. The Mental Health Ministry will be no exception. The covenant set will last beyond the initial implementation of the program. The commitment within the Mental Health Ministry will be unique to the parish community's needs, but the heart of service will never change. To help ensure that the covenant and purpose are clear, Mental Health Ministry Teams may consider publishing job descriptions or clear lists of roles and responsibilities, qualifications and skills, as shown in Appendix.

Because of the relative novelty of Mental Health Ministry programs within Roman Catholic communities, it will be important for a clear articulation of the “what” and the “how” of your parish's Mental Health Ministry program. What is the commitment and how will it be achieved? This will inform and clarify with the community the commitment your ministers are making, and help the congregation to understand the purpose of the ministry and what to expect. To accomplish this, you may consider creating a Mental Health Ministry Mission Statement, to be explicit about the purpose of the ministry and what you all promise to work toward as a community. Alternate or additional options include creating spaces on the parish bulletin, website, and social media outlets to expose the congregation to the ministry's presence and purpose. However the covenant is established and publicized, each individual

Mental Health Minister and the Team as a whole will need to understand, accept, and work to fulfill the commitment.

Covenant requires follow-through. The Mental Health Ministry Team must enact the mission to which they agree. From education to evaluation, there is a renewed commitment along every step of the implementation. Additionally, from day-to-day, there should be follow-through so that the promise is fulfilled. Seek learning; network and collaborate with mental health professionals and local agencies; be active ministers; create events that will support the mental health needs of the parish; connect and advocate for the best interest of the parish community; and be open to evaluation and evolution as the world of mental health and the makeup of the congregation continue to change. A balanced Mental Health Ministry Team will utilize the strengths and styles of each of their members and will put these strengths to action. **Covenant means action.**

STEP 3: WELCOME

Who will we serve? Everyone. As the Mental Health Ministry Team begins its service, it may or may not be clear who the audience will be. The ministry is open to anyone experiencing mental health problems and their family members, caretakers, and loved ones who may be impacted by the person's mental health challenges. This means that Mental Health Ministers can expect to encounter people coping with their own symptoms and concerns, as well as those struggling with the challenges a mental health diagnosis has brought on the family, partnership, friendship, or even workplace. Everyone should be radically welcome, including churchgoers and those who

are already active in other parish ministries or programs. The parish's Hospitality Team (i.e., greeters, ushers, etc.) can be trained on how to welcome *all* congregation members, and all parish staff, volunteers, and ministers should be aware of the Mental Health Ministry services. Again, mental health issues affect people of all backgrounds and demographics, so there should be no exclusion as to who can be included in the ministry.

As mentioned, mental health problems can bring up a sense of isolation—the person with the mental health issues feels that no one understands; the person close to someone with a mental health condition fears judgment and feels helpless. By welcoming and embracing everyone into the Mental Health Ministry, there is a chance to work against the isolation and provide gentle companionship to all. Consider times where ministers can accompany those with mental health problems and their loved ones: during Mass so that they can encounter Christ through the Liturgy, at parish functions so they can feel a part of the community, and during other celebrations and special events to journey with the seasons of the Church. Accompanying and welcoming can happen outside of the parish grounds, too, through Ministers going to local mental health agencies or joining their parishioners at functions that support their wellness and growth. Any opportunity to be a companion for congregation members experiencing mental health problems and/or their family and loved ones is a chance for learning, healing, and treatment.

Mental Health Ministers should also be prepared to embrace difficult times. Parishioners with mental health conditions or their loved ones may experience hospitalizations, enter/exit intensive treatment programs, relapse, or have sudden/rapid decline in

functioning. The Ministry should continue to welcome, remembering again that we are all one body in Christ. **Because of the stigma and presumed judgment behind severe mental health issues, these serious times are often not shared with others**—those suffering from a mental health condition and their loved ones must carry on as if nothing is happening, for fear they may be treated differently. For example, if a neighbor sees the police at a home because someone has just been in a serious car accident, the neighbor might pour out sympathy and even offer help around the house. If a neighbor sees the police at a home because of someone's suicidality, they might gawk, close their doors, or question what is "wrong" with the person. In the case of hospitalizations, what would be the difference between someone being hospitalized due to complications from cancer or diabetes, and someone being hospitalized due to complications from bipolar disorder or substance use disorder? While this may not be true in every case, the person with a mental health issue and/or their loved ones might fear or even experience that this is their reality. During these times, the presence of Mental Health Ministers will be most welcome.

As mentioned, creating a safe and inclusive environment where vulnerability and authenticity are welcomed will make a difference in how the Mental Health Ministry program is received. When parishioners identify Mental Health Ministry as a program where support, emotional security, resources, and accompaniment are all provided, then the ministry is on target.

STEP 4: SUPPORT

Through open brainstorming and consideration of what is feasible and suitable for your congregation, the Mental Health Ministry Team can create many different avenues through which support can be provided to those with mental health challenges and their loved ones. Mental Health Ministry is a ministry for everyone and buy-in is necessary from the top-down and the bottom-up. By creating programs and dialogues where everyone is on an equal plane, we are reaching across to one another to facilitate a successful and transformative ministry. Here, we offer some basic ideas that can be implemented as you see fit.

Mental Health Ministry Family Nights—Some churches may already have programming for “Faith and Family Nights” or other opportunities for families to gather together in directed and guided faith-based events. Mental Health Ministry Family Nights can be an adaptation of these nights, with a focus still on programming that brings the family closer together in a faith context. The difference would be in the level of sensitivity that Mental Health Ministry Family Nights would have for the needs of those experiencing mental health problems and their families. There can be standalone Mental Health Ministry Family Nights:

- Educational nights can provide information and opportunities for having the “tough conversations” that families tend to avoid.
- Witness stories and resources can be candidly shared to help others know they are not alone.
- Movies that build family values or incorporate aspects of mental health can be screened for everyone.

- Ask your congregation; those in need can best identify the help they seek. If standalone events do not seem reasonable, accommodations can be made at any church-sponsored event to ensure that members of the congregation who are dealing with mental illness in one way or another are respectfully incorporated:
- Accommodations for children with developmental or behavioral needs can be made (i.e., less visual and/or auditory stimulation) so that everyone can joyfully participate in different parish events.
- A clear agenda or opportunities for quiet or individual time (not all mingling and unstructured) would help those with anxiety.

Finding ways to make already established parish events sensitive to those with mental health problems could be an easy place to start as your Mental Health Ministry Team decides what programs to sponsor.

Active Outreach—Mental Health Ministry may not receive a flood of people coming forward for support and services, and understandably so. As mentioned, it can be difficult to acknowledge symptoms and admit to the struggle and impact of mental health problems. Thus, it will be imperative for Mental Health Ministry Teams to be prepared to reach out to the congregation, in careful and sensitive ways. Realistically, those with severe, chronic, or declining mental health conditions may not be attending Mass, prayer services, or other parish events. As the Mental Health Ministry progresses and develops a reputation, some of these individuals will come forward. However, with active outreach incorporated as everyone's responsibility, more contact can be made. Other ministers,

volunteers, and leaders in your parish can make referrals to the Mental Health Ministry Team when they believe someone can benefit from connecting with the Team. They can refer to everyone, from those directly experiencing mental health problems, to family members who may be coping with a loved one's new diagnosis, worsening of symptoms, or any other adjustment to mental health conditions. This is why it would be important for everyone connected to the parish—from congregation to leadership—to have a clear understanding of the services and mission of the Mental Health Ministry Team, so that help-seeking behavior is encouraged and accomplished.

Active outreach can take place within the parish grounds, but also out in the community. As mentioned in the “Welcome” implementation step, just as someone would be visited if they were hospitalized for a complication from a medical condition, so Mental Health Ministers can consider reaching out by visiting those who have been hospitalized due to complications from their mental health condition. The parish's Extraordinary Ministers can be sure to coordinate and include those hospitalized or “shut-in” because of mental health conditions in the distribution of the Eucharist. A Mental Health Ministry Team that is visible both at the parish and out in the community has a strong potential to make a difference.

Support Groups or Meetings—Many of you may have participated in or have a vision of what a support group can look like: people with some common interest or problem sitting in a circle of chairs in a nondescript room sharing answers and stories as prompted by a facilitator. This is, in fact, not far from reality. Mental Health Ministry Teams should consider the power of offering support groups or meetings to the congregation. Support groups and

meetings have the potential to bring people out of isolation, empower groups of people to initiate growth and transformation, supplement the progress of someone experiencing mental health issues, and provide loved ones with validation and solace. Support groups, however, cannot simply be facilitated by just any volunteer or Mental Health Minister. Specialized training and practice are necessary to understand how to manage group dynamics, how to respond to delicate or escalated situations, how to manage participants, how to properly start and end the group, and much more. For this reason, an alternate suggestion is to offer the parish facilities (i.e., multipurpose rooms) to organizations with trained facilitators who are in need of a home. For example, 12-Step Programs could be allowed to use a room once each week at a programmed time. While this can be limited to members of the congregation only, it could be an “open” group or meeting that brings in new people and spreads the reach of the Mental Health Ministry program. These support groups could be run on a rotating series, so that for eight to twelve weeks at a time, one support group or meeting could be held with a specific topic, and then the topic or emphasis could change for the next series. Should the Mental Health Ministry program at the parish begin to thrive, many groups or meetings could be held simultaneously—and the impact would be remarkable.

If the coordination of hosting support groups or meetings at the parish facilities proves to be a daunting or a less-than-thriving venture, Mental Health Ministers can attend community-based support groups or meetings with those interested. For example, a local agency may be hosting a grief support group for families who have lost a loved one to suicide, and supporters are welcome. The

Mental Health Ministry program can promote this opportunity and offer to accompany anyone interested to the support group on an ongoing basis. Many support groups or meetings allow “supporters” to attend—someone who is companioning an attendee but does not necessarily need to participate or is not looking to benefit from the service. For instance, a supporter attends the grief support group from the previous example but may not be experiencing grief themselves; they are simply in attendance to help encourage the person whom they are accompanying. Mental Health Ministers acting as supporters at nearby support groups or meetings has the potential to empower the congregation to access services and support they would not otherwise seek or feel comfortable accepting on their own.

Resources and Referrals—An essential aspect of offering support to those experiencing mental health difficulties and their loved ones is to assist in the navigation of the many resources and agencies available. Supporting someone as they find, attempt to access, and accept services or assistance from a resource has the potential to be a full-time job in itself. However, as has been mentioned, providing a robust listing of local mental health agencies/professionals or other resources on the parish website, bulletin, or other forms of social media and communication will be a simple but powerful way to offer support and ministry to others.

STEP 5: ADVOCACY

The very wise St. Teresa of Calcutta is credited with telling us, “Prayer in action is love. Love in action is service.” To take this concept one challenge further, **service in action is advocacy.**

Ministry is a call to service, and without advocacy—taking fellowship and accompaniment into an active supporting role—ministry can become complacent, accepting the way things are and never venturing into new arenas. Without advocacy, the congregation we serve may continue to find limitations to the support they desperately need. The field of mental health is synonymous with advocacy, given layers of bureaucracy and the intersection of many systems. Advocacy, therefore, will be an essential step of the Mental Health Ministry: putting our service into action.

Within the parish, advocacy can take the form of embracing skeptics. There are many who will question why the Mental Health Ministry is necessary and will challenge whether the Mental Health Ministry should be a parish-funded service. Again, it is imperative that Education and Covenant are strongly incorporated into the Mental Health Ministry as a foundation to the program. Ministers will need to embrace discomfort and acknowledge that they are not necessarily experts in the field of mental health. It is understandably despairing to be challenged or questioned when all we want to do is help those in need. As opposed to embracing defeat, have faith. Pray through the doubt and know that advocacy will look like continuing to serve, continuing to learn, continuing to encounter, and continuing to hope—because this is what those with mental health challenges need the most.

Advocacy will also require reaching out. Because the Mental Health Ministry is still developing within the Catholic Church, much of the necessary information and even programming will come from outside sources. Encourage your congregation to participate in mental health events sponsored in the nearby community. Many

cities throughout the United States have local organizations that are dedicated to raising awareness and providing education around mental health issues. There can be local “walks,” conferences, or “mental health fairs” that Mental Health Ministers and congregations can benefit from attending. For example, creating a team for the local mental health-related 5K walk/run can be an active way (literally) to be in solidarity with those experiencing mental health concerns. When programming at the parish feels like you are creating too much from scratch, look outside of the parish and partner with others in the community or other churches to keep the Mental Health Ministry program vibrant and diverse. Hosting a Mental Health Fair on parish grounds by inviting local agencies or groups who want to connect with others experiencing mental health issues can be a great way to advance the Mental Health Ministry program and continue to spread awareness and fight stigma surrounding mental illness.

Networking is another way that advocacy can be woven into the Mental Health Ministry. Connecting with other Mental Health Ministry Teams at other parishes, and dialoguing with mental health professionals to know what others are facing—questions, trends, barriers, and successes—will enrich the Mental Health Ministry program. Regular collaboration with mental health professionals will not only ensure ongoing education but can also help Ministry Teams to understand what barriers to mental health care exist and what options for treatment are available. Advocacy in the form of communicating with mental health professionals about spiritual considerations can also transform the treatment they are providing.

STEP 6: EVALUATION

The success of the Mental Health Ministry can be measured by the degree or depth of implementation. We propose a tiered method for evaluating the depth of implementation presented in the Mental Health Ministry Implementation Matrix (MHMIM) presented on the next page. Each tier can also be thought of as a year in the life of the ministry, with an overall span of three years for full ministry implementation. The MHMIM is a tool designed for self-evaluation and can be used biannually (e.g., every six months) by both parish-level ministry teams as well as diocesan-level ministry coordinators, organizers, or directors.

MENTAL HEALTH MINISTRY IMPLEMENTATION MATRIX

(**Abbreviations:** HIPAA=Health Insurance Portability and Accountability Act; MHM=Mental Health Ministry):

CRITERION (SCORE 0 IF ELEMENT IS ABSENT)	TIER 1 – BEGINNING IMPLEMENTA TION (1 POINT)	TIER 2 – MODERATE IMPLEMENTA TION (2 POINTS)	TIER 3 – DEEP IMPLEMENTA TION (3 POINTS)	SCORE
1. Mental Health First Aid Training	Ministry Leader Only	Most team members certified	Requirement to serve on Mental Health Ministry Team	

2. Documentati on of Implementati on	None	Minimal record of ministry work	Articulated, detailed, organized	
3. Evidence of Impact	None	Minimal evidence of ministry impact (i.e., numbers of events held per year and attendance data)	There is systematically collected qualitative and quantitative evidence of ministry impact. This may include focus group data, survey data, and external indicators, such as changes in Mass attendance or measures of parish social climate	
4. Mental Health Ministry	Fewer than 4 events per year	Between 4 and 11 events per year	Monthly events	

Support/ Outreach				
5. Accompaniment and Direct Support	Nonspecific to MHM (clergy and/or lay ministers may be available for accompaniment)	MHM team members provide on an as-needed basis	Specific MHM team members are identified to facilitate support groups and also provide individual accompaniment	
6. Fiscal Sustainability /Budget	None or time-limited funding (i.e., grant or gift)	Time-limited funding stream with minimal records of budget	Articulated budget with reliable funding streams to ensure sustainability of MHM activities after expiration of grant or gifts	
7. Provider Referral System/Network	MHM Team has identified local providers and makes	Some referral communications are within a secure,	All referral communications are within a secure,	

	appropriate referrals	HIPAA-compliant system	HIPAA-compliant system. Providers are vetted and respect Catholic beliefs.	
8. Pastoral Support	Pastor is aware of the ministry	Pastor is supportive of the ministry, attending up to 3 meetings or events per year	Pastor is fully engaged in the ministry, attending up to 6 meeting or events per year and speaks on behalf of the ministry at events or from the pulpit	
			TOTAL	

This matrix is designed as a self-assessment and progress monitoring tool to evaluate the depth of implementation for mental health ministries.

The MHMIM can also be used as a template for the Mental Health Ministry's implementation plan, with each criterion included as a marker assigned a specific month and year to be implemented over the course of three years. The implementation

plan should be developed by the Mental Health Ministry Team and each criterion should be assigned to a team member (as part of that member’s role) for implementation.

MHMIM Scoring

The MHMIM is scored as follows:

**MENTAL HEALTH MINISTRY IMPLEMENTATION MATRIX (MHMIM)
SCORING TABLE**

IMPLEMENTATION LEVEL	MHMIM SCORE RANGE	BENCHMARK TIER/YEAR
Deep	20-24	Tier 3/Year 3
Moderate	16-19	Tier 2/Year 2
Beginning	15 and below	Tier 1/Year 1

Leveraging Technology to Support Ministry

Many dioceses and churches throughout the United States have embraced the “mobilization” of ministry through the incorporation of technological platforms. Indeed, our collective experience with the 2020 COVID-19 pandemic has made technology essential to ministry. There is no doubt that we are embedded in an age where accessing information is expected to be quick and “user-friendly,”

given the tiny computers many of us use as cell phones these days. Levering technology to support any parish effort can seem daunting and time consuming. Keeping up with business-related emails could be a part-time position alone in many parishes! Whatever level of comfort you or your parish has with incorporating technology into ministry programs, our suggestions here for using technology to support the Mental Health Ministry will not require a full technology support team, guaranteed.

As mentioned, explaining the purpose and services of the Mental Health Ministry Team will be essential to harnessing the buy-in of the congregation. However, repeating this in the weekly printed bulletin will not only take away prime real estate from other parish ministries but the constant inundation could breed complacency, and the valuable ministry could be ignored. Instead, posting the Mental Health Ministry's Mission Statement and list of services on the parish website, whether it is through a special article or a webpage of its own, creates a single platform to which people can be directed for more information. As the ministry develops, the webpage can become more robust, including links to area-wide mental health resources or referrals for local agencies and mental health professionals who may be able to assist with a variety of mental health conditions. There is great potential in maintaining a Mental Health Ministry-specific webpage. But if this is not within the means of your specific parish, having semi-frequent parish website postings by the pastor or assigned Mental Health Ministers announcing some of the Mental Health Ministry's offerings will still catch attention and spread the word.

If possible, a Mental Health Ministry-specific email address could be one of the main methods for leveraging technology to

support the ministry. Many inquiries, information requests, or even conversations can be fielded through a Mental Health Ministry-specific email address. This would require some coordination regarding who would receive and respond to any electronic communication—would it be one point-person or the whole Mental Health Ministry Team’s responsibility—but the existence of the email address would support and streamline communication with the congregation and collaboration with mental health professionals, agencies, and other parishes. Another consideration when utilizing a central email address is the timeliness of communication. A parishioner may use email as a means to communicate distress or an emerging mental health crisis. If this is the case, checking the Mental Health Ministry email address once a week, while possibly sufficient at first, could result in a lapse in providing timely ministry and support to someone in need. Mind you, neither the Mental Health Ministry website nor email address should be promoted as a means to receive direct and immediate mental health support.

Electronic communication can be used to inform and educate the congregation to ultimately build awareness about mental health and combat stigma and misperceptions. As stated previously, **providing accurate and up-to-date information can help those who question the Mental Health Ministry to feel more comfortable with its validity and can increase help-seeking behavior.** Technology has the potential to reach those who otherwise may not access ministry services at the physical church and provides a platform for collaboration and consultation with mental health providers (Javadi et al., 2017). Voluntary help-seeking is difficult for many people who need mental health services. The idea

of walking up to someone and admitting mental health concerns can be intimidating.

Communicating with a Mental Health Minister via email or gathering information through online sources linked to the parish website could be more of an attainable first step for finding mental health support. By properly leveraging technology, Mental Health Ministry can build connections with the congregation and will take another step in fighting isolation and mental health stigmas. It is important that sensitive personal mental health information about parishioners in need of referrals not be shared with other ministry team members or in a referral to a provider over a standard email system or other nonsecure means (i.e., texting, IMS, or social media direct messaging). It is strongly recommended that dioceses and parishes use secure, Health Insurance Portability and Accountability Act (HIPAA)-compliant systems for such purposes. Indeed, some systems offer functionality to organize referral groups and vet the licensure status of mental health providers, often at no cost to the diocese or parish.

Again, whatever technological effort is possible given the means and circumstances of your parish will be another mental health support that may not have previously existed for your congregation. You can start small—creating an email address—and see how the congregation responds. As the Mental Health Ministry Team builds services and credibility, the use of technology can progress as well. However, incorporating some form of online presence from the very beginning will ensure that the Mental Health Ministry is an embedded part of your parish's listed ministries and will help in the promotion of the services. It was previously explained that the congregation should be surveyed to learn what mental health needs

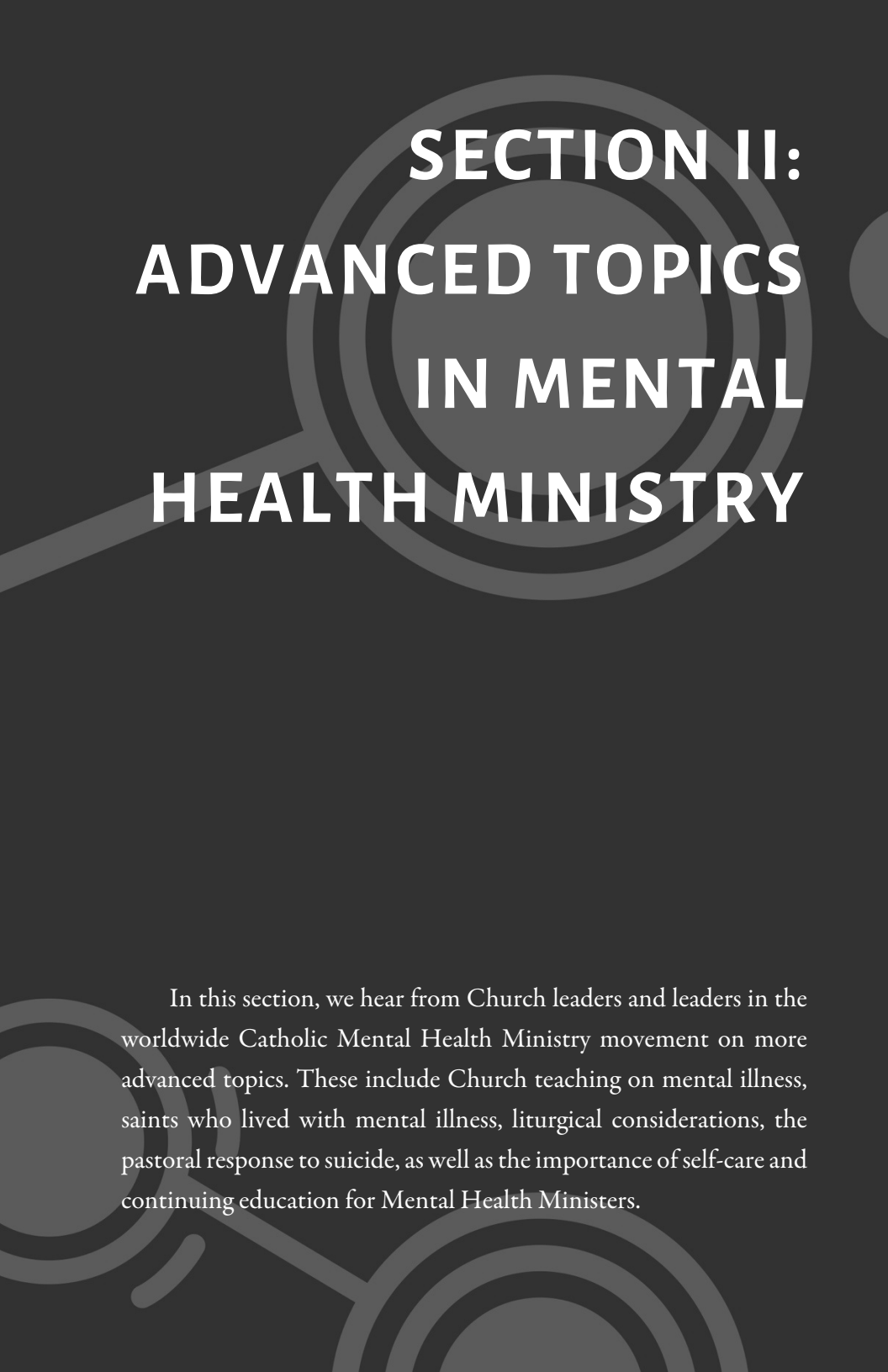
exist in the parish, to help identify direct mental health topics that could be addressed in strategic ways. Would it be possible to survey your congregation via online or email survey? If not at first, would this be a helpful communication tool for the Mental Health Ministry and all ministries involved at the parish? While incorporating technology can seem unnecessarily taxing, it will prove to be beneficial. The Mental Health Ministry's use of technology can disseminate appropriate information, can transform help-seeking behavior by those hesitant to access face-to-face services at first, and can be a model of openness to emerging thinking and ministry. When so much of social media and online communication is contrived, glamorized, secular, and politicized, the Mental Health Ministry's authentic communication can be a powerful voice of compassion and hope.

CHAPTER 8 ENRICHMENT ACTIVITY

For personal and/or Team reflection, examine the following questions:

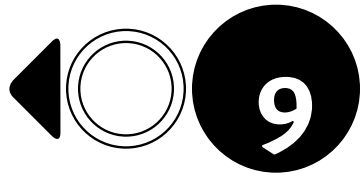
1. Determine an implementation timeline—with clear deadlines—that is realistic for your parish.
2. To ensure fidelity and efficacy, assign different members of the Mental Health Ministry Leadership Team one of the six implementation steps identified in this chapter. Consider holding a retreat or planning day for the MHM Leadership Team to plan goals, objectives, and action items.
3. Do a quick internet search of any mental health related topic (i.e., “help for anxiety”) and note the plethora of

results. Independent help-seeking can be discouraging and overwhelming. Taking this perspective, what can your Mental Health Ministry Team do to leverage streamlined and direct technology services to your constituents?

The background is dark gray with several concentric circles in a lighter gray shade. A magnifying glass graphic, also in a lighter gray, is positioned behind the text, with its handle extending from the bottom left and its lens framing the title. The title is written in a bold, white, sans-serif font, centered on the page.

SECTION II: ADVANCED TOPICS IN MENTAL HEALTH MINISTRY

In this section, we hear from Church leaders and leaders in the worldwide Catholic Mental Health Ministry movement on more advanced topics. These include Church teaching on mental illness, saints who lived with mental illness, liturgical considerations, the pastoral response to suicide, as well as the importance of self-care and continuing education for Mental Health Ministers.



CHAPTER 9

CHURCH TEACHING AND DOCUMENTS ON MENTAL ILLNESS

DEACON ED SHOENER

This chapter presents summaries of recent papal teachings and other significant Church documents on mental illness. Along with references, there are also links to the complete documents for further reading.

The recent popes have shown compassion for people who live with mental illness and a deepening understanding of the psychology and underlying causes of mental illnesses. The Vatican has held conferences and issued reports where theologians, Church leaders, and medical experts have offered reflections on mental health issues and pastoral care. In addition, some bishop conferences have issued detailed statements on mental health.

Papal Statements on Mental Illness

POPE SAINT JOHN PAUL II—"CHRIST TOOK ALL HUMAN SUFFERING ON HIMSELF, EVEN MENTAL ILLNESS"

Pope Saint John Paul II eloquently stated the importance of attending to the spiritual life of people who live with mental illness. In a speech to the International Conference for Health Care Workers, on Illnesses of the Human Mind in 1996, he said:

Christ took all human suffering on Himself, even mental illness. Yes, even this affliction, which perhaps seems the most absurd and incomprehensible, configures the sick person to Christ and gives him a share in His redeeming Passion. ... 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.

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... .

In a speech to the International Conference for Health Care Workers, on Depression in 2003, Pope John Paul II recognized the important role of pastoral care in supporting people experience depression. He said:

The role of those who care for depressed persons and who do not have a specifically therapeutic task consists above all in helping them to rediscover their self-esteem, confidence in their own abilities, interest in the future, the desire to live. It is therefore important to stretch out a hand to the sick, to make them perceive the tenderness of God, to integrate them into a community of faith and life in which they can feel accepted, understood, supported, respected; in a word, they can love and be loved. For them as for everyone else, contemplating Christ means letting oneself be “looked at” by Him, an experience that opens one to hope and convinces one to choose life.

POPE BENEDICT—“WE MUST DO WHATEVER WE CAN ... TO GIVE ASSISTANCE IN OVERCOMING MENTAL SUFFERING.”

Pope Benedict XVI highlighted the need for countries and individuals to take action to treat mental illness and to respect the dignity of people who live with mental illness. In a message on the World Day of the Sick in 2005, he said:

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.

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.

In his 2007 encyclical titled *Spe Salvi* (*Saved in Hope*), Pope Benedict recognized mental suffering, and although he recognized that we may not be able to eliminate all suffering, said the Church needs to help reduce the suffering:

We must do whatever we can to reduce suffering; to avoid as far as possible the suffering of the innocent; to soothe pain; to give assistance in overcoming mental suffering. These are obligations both in justice and in love, and they are included among the fundamental requirements of the Christian life and every truly human life.

POPE FRANCIS—"FULLY OVERCOME THE STIGMA WITH WHICH
MENTAL ILLNESS HAS OFTEN BEEN BRANDED"

Pope Francis has called attention to the stigma and discrimination often confronted by people who live with mental illness. In a speech in 2021 Conference for Mental Health Workers, he called instead for a culture of community. He said:

It is also a question of helping to fully overcome the stigma with which mental illness has often been branded and, in general, to ensure that the culture of community prevails over the mentality of rejection, according to which greater care and attention is given to those who bring productive advantages to society, forgetting that those who suffer allow the irrepressible beauty of human dignity to shine forth in their wounded lives.

In November 2021, Pope Francis's monthly prayer intention was entitled *People Who Suffer from Depression* (Vatican News, 2021). In this prayer, the Holy Father recognized the importance of psychological counseling and to accompany and be close to those who are depressed and offer hope:

Let us try to be close to those who are exhausted, to those who are desperate, without hope. Often, we should just simply listen in silence, because we cannot go and tell someone, "No, life's not like that. Listen to me, I'll give you the solution." There's no solution. And besides, let us not forget that, along with the indispensable psychological counseling, which is useful and effective, Jesus's words also

help. It comes to my mind and heart: “Come to Me, all who labor and are heavy laden, and I will give you rest.” Let us pray that people who suffer from depression or burn-out will find support and a light that opens them up to life.

On World Mental Health Day 2021, Pope Francis prayed for those who have died by suicide and offered support:

I would like to remember our brothers and sisters who suffer from mental illness, and also victims—often young people—of suicide. Let us pray for them and their families, so that they are never left alone, or discriminated against, but instead are welcomed and supported.

Pope Francis has also spoken about how he himself received treatment from a psychiatrist during a stressful period in the 1970s when he was serving as the Jesuit Provincial in Argentina. In a 2021 interview with Courtney Mares, he said: “Treatment with the psychiatrist also helped me locate myself and learn to manage my anxiety and avoid rushing when making decisions.” He went on to say that it is important that priests understand psychology: “I am convinced that every priest must know human psychology. There are those who know it from years of experience, but the study of psychology is necessary for a priest.”

Vatican Conferences and Documents

In recent years, the Vatican has convened conferences on mental health and has issued reports and messages about mental health. Listed below are brief excerpts or summaries from these

documents along with references to locate the documents for more in-depth reading.

MESSAGE OF CARDINAL PETER TURKSON OF THE PREFECT OF THE
DICASTERY FOR PROMOTING INTEGRAL HUMAN DEVELOPMENT FOR
WORLD MENTAL HEALTH DAY (OCTOBER 2021)

This message was issued to call greater attention to the need to break down the stigma associated with mental illness. “One of the most neglected dimensions in the broad universe of health is mental health, which is often accompanied by stereotypes, and lack of knowledge about specific issues and misinformation. We are all called to be close to our brothers and sisters with mental illness, to fight against all forms of discrimination and stigma against them.”

REPORT FROM THE DICASTERY FOR PROMOTING INTEGRAL HUMAN
DEVELOPMENT: ACCOMPANYING PEOPLE IN PSYCHOLOGICAL
DISTRESS IN THE CONTEXT OF THE COVID-19 PANDEMIC (NOVEMBER
2020)

This report was issued during the COVID-19 pandemic. “The global epidemic of COVID-19 has challenged our physical resistance and revealed the fragility of our bodies. It has also affected the psychological balance of many people. The Church, in each of its members, is called to live a mission that is, above all, a presence. Accompaniment is a delicate attention, a solicitude that breaks loneliness. ‘I think and will think of you; think also of me’: this is the message of discreet and respectful accompaniment. With living accompaniment, we understand that we accompany one another.”

PROCEEDINGS OF THE XVIII INTERNATIONAL CONFERENCE
ORGANIZED BY THE PONTIFICAL COUNCIL FOR HEALTH PASTORAL
CARE DEPRESSION (NOVEMBER 2003)

The conference was dedicated to studying at a deep level what depression is, what the Word of God tells us about depression, and in practical terms what can be suggested for the cure of this illness. Pope Saint John Paul II (2003) addressed the conference, and the proceedings contains twenty-seven papers on depression, with many of the papers focusing on the pastoral care of people suffering from depression.

PROCEEDINGS OF THE ELEVENTH INTERNATIONAL CONFERENCE
ORGANIZED BY THE PONTIFICAL COUNCIL FOR PASTORAL
ASSISTANCE TO HEALTH CARE WORKERS “IN THE IMAGE AND
LIKENESS OF GOD: ALWAYS?” DISTURBANCES OF THE HUMAN MIND
(NOVEMBER 1996)

Researchers, scientists, scholars in biomedicine, theology, psychiatry, psychology, sociology, and moral theory addressed various questions concerning the structure of the human mind, the facts on the widespread presence of mental illness, its direct and indirect causes, and the means of prevention, treatment, and rehabilitation. Presentations were made on the tasks and methods of helping and caring for the mentally ill—both from a clinical point of view and in terms of pastoral assistance. The hope of the conference organizers was that the ecclesial community will become ever more sensitive to the questions and problems of the mentally ill. Pope Saint John Paul II addressed the conference, and the proceedings contain fifty-five papers on a wide variety of topics.

Bishop Conference Documents

The Conference of Bishops from California and Australia have issued significant documents on the role of the Church in caring for people who live with mental illness.

HOPE AND HEALING: A PASTORAL LETTER ON CARING FOR THOSE WHO SUFFER FROM MENTAL ILLNESS, CALIFORNIA CATHOLIC CONFERENCE OF BISHOPS, UNITED STATES (2018)

California's Catholic bishops issued a letter on serving those who struggle with mental illness, stressing that "ministering to those who suffer from mental illness is an essential part of the pastoral care of the Church." The letter is addressed to Catholics and all people of goodwill, and it encourages all people to care for and meet the needs of those who suffer from mental illness. The letter also stresses the importance of not judging or stigmatizing those who suffer from mental illness, and the need for healthcare professionals and scientific researchers to work with the Church to improve mental health care. The eleven-page document focuses on six primary principles:

- Christ calls us to attend to those who suffer from mental illness and provide hope and healing.
- The scope and burden of mental illness in our society is enormous.
- Those suffering mental illness should not be stigmatized or judged.
- The Church, health care professionals, and scientific researchers should work together to improve mental health care.
- We must meet and attend to those in need where they are.

- Those impacted by suicide need our compassionate response.

The bishops conclude by stating: “Just as Christ never abandons anyone, so also the Church never abandons those who suffer from mental illness. We encourage all Catholics—clergy, religious, and the lay faithful—to partner with others of goodwill in this indispensable work of healing and caring for those with mental illness. Our Catholic faith provides us with this consolation and this firm hope, which strengthens our resolve: In eternity with God, every beautiful thing in our lives that is now unfinished will be completed, all the good that is scattered will be gathered together, everything that is lost will be found, all hopes that are now thwarted will be realized and all that is broken will finally be restored.”

TO LIVE LIFE TO THE FULL: MENTAL HEALTH IN AUSTRALIA TODAY,
SOCIAL JUSTICE STATEMENT, AUSTRALIAN CATHOLIC BISHOPS
CONFERENCE (2020–2021)

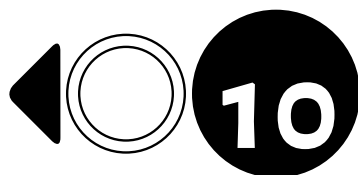
The Catholic bishops of Australia encourage faith communities, governments, and each one of us to make mental health a priority. The Australian bishops state clearly that mental ill-health is not a moral failure, or the result of a lack of faith or of a weak will. People experiencing mental ill-health are not some “other” people; they are “us.” People in our families, faith communities, workplaces, and society are suffering mental ill-health – and they can be of any age or socioeconomic background. Whoever and whatever they are, they need our understanding and support. The bishops invite us all to reject stigmatization, to work for the transformation of social determinants of mental ill-health, and to call for policies and

service provision that meets the needs of the poorest and most marginalized members of our community.

The twenty-page document is divided into four sections:

- The mental health of our people and communities
- The great project of community integration
- We are all in this together
- Called to live life to the full

The bishops conclude by stating: “In our parish communities, our institutions, and throughout the Church in Australia, we have a duty to break through the stigma of mental illness. As Church, we have the opportunity and responsibility ... to consider at a deeper level our care for these most vulnerable of our brothers and sisters. We are called to restore the Body of Christ by making mental health a key priority, acknowledging and including people living with mental ill-health within our communion and the heart of Australian society.”



CHAPTER 10

SAINTS WHO LIVED WITH MENTAL ILLNESS

DEACON ED SHOENER

Did any of the saints live with a mental illness? Yes, most certainly some of them did. They were human. Mental Illness has always been part of the human condition. Saints lived with every kind of illness, and those who lived with mental illness can give hope to the millions of people who live with mental illness today.

Suggesting that some saints lived with a mental illness does not diminish their legacy. To believe that would only perpetuate the stigma and discrimination that people who live with mental illness must endure; it would infer that living with a mental illness makes a person less worthy of God's grace.

The reality is that people who live with a mental illness can have deep and profound insights into suffering and the mercy of God. God's grace is not limited by any condition, including mental illness. People who live with a mental illness can be especially close to God and live holy lives.

People with mental illness are uniquely joined to Christ. Pope Saint John Paul II said: "Christ took all human suffering on Himself,

even mental illness. Yes, even this affliction, which perhaps seems the most absurd and incomprehensible, configures the sick person to Christ and gives him a share in His redeeming Passion.”

There are saints whose legacies have inspired entire communities to value and accompany people who live with a mental illness. The legacies serve as inspiring models for mental health ministry.

Saint Dymphna

Saint Dymphna is well known as a patron of people living with mental illness. She was a seventh-century Irish princess who fled from her father, who seems to have had a mental illness, and she settled in Geel, Belgium, where she cared for people with mental illnesses. Because she lived so long ago, much of her story is shrouded in the mist of legend, so it is difficult to know with certainty much about Dymphna herself.

However, what is known with certainty is that Saint Dymphna’s legacy inspired the people of Geel to show compassion for people who live with mental illness. Over the centuries, the people of Geel invited people with a mental illness to live and work in their community without any stigma or discrimination. Throughout the Middle Ages and even today, the town of Geel is known as a model for community acceptance of people who live with a mental illness.

As awareness and openness about mental illness has increased, Saint Dymphna is being venerated by a new generation. In recent years, “Dymphna” has become an increasingly common confirmation name for young adolescent girls.

Saint John of God

The legacy of Saint John of God continues to inspire people to provide good and compassionate medical care for people who live with mental illness. Saint John of God lived in Spain in the 15th century. In his mid-life, his mental health deteriorated, and he was sent to the Royal Hospital in Grenada, Spain, a psychiatric facility. As was typical at that time, his care was harsh and inadequate. Despite this treatment, over time John recovered and he was able to visit with other patients and help the nurses in their care of those patients. After he was released from the hospital, John dedicated himself to help the poor, sick, and homeless, who often lived with a mental illness.

He drew followers who were inspired by his holiness and compassion. Today, his followers are known as the Brothers Hospitaller of Saint John of God. The Brothers Hospitallers continue his mission of caring for the poor and those with mental illness by operating hospitals and medical care facilities in more than 50 countries.

The Martin Family—Saint Thérèse of Lisieux and her parents Saints Louise and Zélie Martin

Families around the world face mental health challenges. Many families offer unconditional love to family members who live with mental health challenges, and in doing so the entire family advances in holiness.

A famous family of saints, the Martin family of Lisieux, France, showed us how a family can support each other in facing mental health challenges. The parents of the family, Saint Louis and Saint

Zelie Martin, raised nine children, among them Saint Thérèse of the Child Jesus.

The father, Saint Louis Martin, suffered from a painful and humiliating mental illness. A month after Saint Thérèse received her religious habit, a joyous time in the life of the Martin family, she and her sisters experienced the great suffering of having their father admitted to a mental health hospital because he was experiencing delusions and disordered thoughts.

Saint Thérèse saw this as a type of martyrdom for the family and wrote to her sister, “Let us enter the arena together.” She recognized the need for family support, writing to her aunt, “How kind Jesus is in allowing us, in the cruel trial He is sending, the consolation of seeing our sorrow shared and understood by our kind relatives!”

Prophetically, she said of her family’s experience with this mental health crisis, “What a joy to be humbled; it is the only thing that makes saints!”

This family of saints understood the difficult reality of caring for a loved one with a mental health disorder, yet they faced the challenges together as a family and helped lead each other to gates of heaven.

Many Saints Who Lived with Mental Illness

Not surprisingly many other saints lived with mental illness. Since 20 percent of the United States population lives with a diagnosable mental health disorder at any one time (Substance Abuse and Mental Health Services Administration, 2017), and over the course of a lifetime about 50 percent of the population will experience a mental health disorder (Kessler et al, 2005), it should be

expected that many saints faced mental health challenges and lived with a mental health disorder.

The book *No Unlikely Saints—A Mental Health Pilgrimage With Sacred Company*, written by Cameron Bellum (2021) is a devotional on the saints and mental health. The lives of these holy men and women demonstrate that mental health concerns are no disqualifier for holiness and a meaningful, fulfilling life. Bellum writes: “Ask these incredible saints to walk alongside you as you step out of the darkness of shame into the light of love and acceptance. Be assured that have access to deeply compassionate and powerful advocates, both on earth and in heaven.”

The California Bishops wrote in their pastoral letter about mental illness titled *Hope and Healing* (2018) that, “Mental illness is neither a moral failure nor a character defect. To suffer from a psychiatric disorder is not a sign of insufficient faith or weakness of will. Christian faith and religious practice do not immunize a person against mental illness. Indeed, men and women of strong moral character and heroic holiness— St. Thérèse of Lisieux, St. Benedict Joseph Labre, St. Francis of Rome and St. Josephine Bakhita— suffered from mental disorders or severe psychological wounds.”

Following is a list (by no means exhaustive) of some additional saints who lived with mental illness:

Saint Oscar Romero lived with obsessive compulsive disorder (OCD)

He was a bishop who was martyred in 1980 for his defense of the poor in El Salvador. In the 1970s while in his forties,

he was diagnosed with OCD and sought out therapy and treatment for his mental illness.

Venerable Rutilio Grande lived with schizophrenia

While in formation he was hospitalized for his mental illness, yet his Jesuit community supported him in pursuing ministry. He was martyred in El Salvador in 1977 for his work among the poor. His death inspired Saint Oscar Romero to serve the poor.

Saint Jane Frances de Chantal lived with depression

She founded the Order of the Visitation of Holy Mary in 1610 with Saint Francis de Sales in France. Before founding the Order, she was married, but she lost two children in childbirth and her husband was killed in a hunting accident. She said that she was often “overwhelmed with darkness and affliction,” yet was able to live a life of holiness and found the energy to help others.

Saint Edith Stein lived with suicidal ideation

She was a convert from Judaism, became a Carmelite nun, and died in a Nazi concentration camp in 1942. As a young woman, she felt isolated and suffered with depression and often thought about suicide. Eventually, she found a supportive Christian community in the Carmelite Order.

Saint Elizabeth Ann Seton lived with anxiety and depression

She was the first American-born saint and founded the country's parochial school system in the early 19th century. She suffered from depression so profound that she thought several times of suicide. She faced many problems during her life, including the death of her husband and challenges with her children.

Saint Mark Ji Tianxiang lived with drug addiction

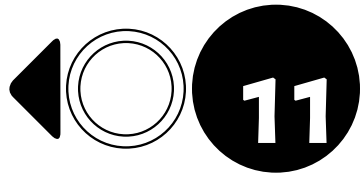
He lived in 19th-century China and became addicted to opium after using it to treat a medical condition, similar to many people today who become addicted to opioids after being treated for pain. Despite his addiction, he preserved as a dedicated Christian and died a martyr at the time of government persecutions of Christians.

The Venerable Matt Talbot lived with alcohol addiction

He lived a simple life working in a lumberyard in the early 20th century in Dublin, Ireland. He was a severe alcoholic for nearly 15 years and finally took a pledge not to drink. He supported his sobriety with traditional Catholic disciplines, such as prayer, frequent communion, weekly confession, spiritual reading, fasting, and service. Eventually, Matt found community support by joining the Secular Franciscan Order.

Saint Benedict Joseph Labre lived with scrupulosity

Known as the Beggar of Rome, he lived in the ruins of the Colosseum in Rome in the 18th century. Early in his life, he was rejected by a number of monastic orders because of his mental illness. He settled in Rome and led a devout life while serving his fellow poor and homeless of the city.



CHAPTER 11

LITURGY, WORSHIP, AND SACRAMENTS

DEACON ED SHOENER

The realities of mental health issues and illnesses must be recognized and incorporated into the liturgy and worship of the Church. In Mass and other worship services, we can acknowledge that many parishioners are facing mental health challenges so that they, and everyone present, understand that they are welcomed and supported by their parish community.

We can break down the stigma associated with mental health challenges by affirming during public worship services the important role that the Church and each parish has in ministering to people with mental health challenges.

We can do as Pope Francis has asked by remembering those who live with mental health challenges and “pray for them and their families, so that they are never left alone, or discriminated against, but instead are welcomed and supported” (2021).

Intercessory Prayers and Prayers of the Faithful

A simple and easy way to begin incorporating Mental Health Ministry into public worship is to reference mental health issues during intercessory prayers. During the Prayers of the Faithful, the Church prays about a wide variety of challenges and topics—and mental health, mental illness, and suicide should be included in these prayers. The Association of Catholic Mental Health Ministers maintains a list of intercessory prayers on its website (CatholicMHM.org). Here are some examples of intercessory prayers:

- For all persons who themselves or within their families live with mental and emotional crises, that the joy and love of Jesus may bring them comfort. We pray to the Lord.
- For all persons who live with mental health concerns, the Church and public agencies will act with justice to ensure the availability of necessary supportive services to aid in their recovery. We pray to the Lord.
- For all persons who face discrimination and stigma due to mental illness, that they will find welcome and inclusion as branches of Jesus's vine. We pray to the Lord.
- For all who provide services for persons whose lives are affected by mental illness—social workers, counselors, mental health professionals, pastoral caregivers—that they will bear witness to God's spirit of love. We pray to the Lord.
- That those who are held captive by an addiction to drugs or alcohol may find the help and support that they need to overcome their illness. We pray to the Lord.
- For those living with a mental illness, depression, and suicidal thoughts—may they find the help and support that

they need to lead peaceful and full lives. We pray to the Lord.

- For families and friends experiencing the loss of a loved one by suicide—may they find healing and comfort in Your Church. We pray to the Lord.

Liturgies for Special Occasions

There are a number of days and months throughout the year that can serve as special times to highlight mental health issues and the needs of people living with a mental illness and those who support them. A parish community could offer a special Mass or prayer services at these times. Announcements should be made in advance about the services that explain how they are connected to the mental health ministry.

An especially important element of these services is to include people who are impacted by mental health challenges and illnesses in the services by having them serve as readers, extraordinary ministers of the Eucharist and when appropriate, as speakers.

It is also a good time for members of the clergy to preach on the topic and, when possible, offer personal reflections on how mental health concerns have impacted them or those close to them, so that those attending the Mass or service realize that mental health issues impact everyone, both laity and clergy.

WORLD DAY OF THE SICK—FEBRUARY 11

Most parishes and dioceses have Masses commemorating the World Day of the Sick. Such Masses offer prayers for people who are ill and have a physical illness, but all too often mental illness is

excluded and not mentioned. A Mental Health Ministry can work to remind the organizers of the World Day of the Sick Masses at the parish to include references and invitation to those who live with a mental illness.

In 2006, Pope Benedict XVI dedicated the Celebration for the 14th World Day of the Sick to those who suffer from mental illness. In his message for that day, he stated: “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....”

SAINT DYMPHNA FEAST DAY MASS—MAY 15 AND MENTAL HEALTH AWARENESS MONTH/MENTAL HEALTH WEEK IN MAY IN THE UNITED STATES, CANADA, AND EUROPE

The month of May provides opportunities to have a special Mass for people living with mental illness and for intercessory prayers and homilies that focus on mental health and how the Church is called to accompany people who live with mental illness.

Saint Dymphna is a patron saint for those who live with a mental health challenge or disorder, and her feast day is May 15. In addition, May is Mental Health month in the United States and Mental Health Awareness week is commemorated in Canada and Europe in May.

May is also a good time to pray a novena to Saint Dymphna. Novenas to Saint Dymphna can be found on a few websites, including the United States National Shrine to Saint Dymphna in

Massillon, Ohio, and on the Association of Catholic Mental Health Ministers site.

WORLD SUICIDE PREVENTION DAY—SEPTEMBER 10 AND SUICIDE AWARENESS AND PREVENTION MONTH IN SEPTEMBER IN THE UNITED STATES

September is a good month to raise awareness about suicide and suicide-prevention activities and programs. It is also a good time to discuss suicide as a parish. Intercessory prayers can be offered for those who suffer with suicidal ideation, those who have died by suicide, and for those who grieve the death of a loved one to suicide.

Many dioceses and parishes also offer a Special Suicide Healing and Remembrance Mass in September. The Mass serves to remember loved ones lost to suicide and to promote healing for those who grieve their passing. During the Mass, those attending can be invited to bring a flower to the altar or perhaps light a candle in remembrance of those lost. This ritual is a way to acknowledge and remember those who have died by suicide and to symbolize our commending them to God's love, mercy, and care.

WORLD MENTAL HEALTH DAY—OCTOBER 10

World Mental Health Day, celebrated on October 10, is an international day for global mental health education, awareness, and advocacy against social stigma. It is an initiative of the World Federation for Mental Health, a global mental health organization with members and contacts in more than 150 countries.

Pope Francis took the opportunity on World Mental Health Day on October 10, 2021, during his Angelus address to ask us “to

remember our brothers and sisters who suffer from mental illness, and also victims—often young people—of suicide. Let us pray for them and their families, so that they are never left alone, or discriminated against, but instead are welcomed and supported” (2021).

October is a good month to host mental health education events at a parish and to partner with community organizations to raise awareness and reduce stigma in the community. Many communities have mental health awareness events throughout the month of October.

LONGEST NIGHT/BLEU CHRISTMAS—DECEMBER 21

People who are facing a mental health challenge, illness, or grief often find the Christmas Season a difficult time. Coinciding with the winter solstice, a longest night service, sometimes called a Blue Christmas service, acknowledges those difficulties and offers prayer, hymns, and reflection to accompany people who are suffering during the Christmas Season. It can be a somber yet hopeful Mass, or the service can be organized as a Taizé prayer service with reflections in between songs and hymns.

St. Thomas More Parish in Chapel Hill, North Carolina, offers a Longest Night service. The prayer service opened with this introduction: “It is the winter solstice, the day that we spend more time under the night sky than in daylight. For many of us, the days will not brighten tomorrow. Loss, grief, loneliness, and disruption darken our hearts and our days. Tonight, we invite you to pray in that darkness. Through scripture and song, we will share our

suffering and distress with our God and with each other. We will ask for peace.”

Homilies and Scripture Reflections

Mental health challenges and illnesses are human experiences that run through Scripture, yet it is seldom referenced in homilies and Scripture reflections. Changing this can help reduce the stigma surrounding the discussion of mental health conditions.

Referencing mental health challenges can also help make homilies more engaging to many people because mental health is increasingly becoming a topic of concern, particularly for young people. Drawing connections between Scripture and mental health challenges can be a way to evangelize in a culture that is becoming more aware of mental health challenges but may not see that Christ and His Church understand mental health challenges. Weaving the references to mental health issues and using the language of mental health care will help people know that the Church accompanies and supports them in their struggles, and can lead them to a deeper relationship with Christ.

At times it may be appropriate to have mental health be the primary focus of a homily or reflection; for example, the liturgies for special occasions mentioned earlier would certainly be appropriate times to focus on mental health.

At other times, it may be better to simply use a mental health issue to illustrate a point that you are making in the context of a homily with a broader focus. For example, if the focus of a homily or reflection is on the mercy of Christ, you could include use as an

example of Christ's mercy how Christ is always merciful to those who live with mental illness, even if many people are not.

There are many general themes that run through Scripture that can be used to preach on mental health issues. A few of these themes are highlighted next and the appendices contain references to websites, books, and other sources of information that can be used to support preachers.

LAMENT AND THE BOOK OF PSALMS

There are many themes found in the book of Psalms, but the idea of man being less than or helpless without the power, grace, love, and guidance of God is clear and can be a helpful anchor when working in the Mental Health Ministry. Psalms 42 and 43 describe the soul as distressed, acknowledge the human feelings of isolation and depression, and end in seeking and calling upon God, putting hope in God for safety and comfort. Many who regularly experience the challenges of mental illness can identify with the desperation expressed in these psalms. Has God forgotten them? Is the oppression and burden of mental health issues a message from God?

The anguish of living with mental health disorders is indescribable. We cannot promise an immediate erasure of the misery. We can, however, remind others to hope in God and never lose sight of God's constant presence, just as the Psalms remind us.

STIGMA AND LEPERS

Imagine having an illness that causes people to condemn you and to treat you with scorn simply because you have the illness. That is what happened to people in biblical times who were infected by

leprosy, a deadly skin disease. Someone who had leprosy was declared “unclean.” They were made to go and “dwell apart.” People thought those infected or their family had done something wrong because they had contracted the illness—a sin, a failing of some kind. There was shame, sadness and even grief—a longing for life before the illness. There was no comfort. And perhaps worst of all—no hope.

Is there anything like leprosy today? Yes, sadly, there is. What if someone told you that you or your child has schizophrenia, bipolar disorder, clinical depression, or some other type of serious mental illness? You would have to face challenges similar to what people who lived with leprosy had to face.

Yet when people with leprosy asked for help, Christ reached out to them. Christ saw them as a people in need and He was moved with compassion. We are called to be a healing presence to help people find wholeness and peace in the midst of mental illness. Our goal is to share our stories, support each other, and pray together so that no one feels alone in their struggle with mental illness.

PERSEVERANCE

The epistles of Saint Paul are helpful, straightforward challenges for ministers to serve and persevere with great love, and reminders for parishioners experiencing mental health difficulties to maintain faith even under the most desperate challenges. The presence of mental illness does not indicate a lack of faith. In the first epistle of Paul to Timothy, we are summoned to “fight the good fight of faith” (1 Timothy 6:12).

This rally call can be a good reminder to those accessing mental health services, as well as for those working in the mental health

ministry—life brings many battles, but we are all armed with faith. In Romans 5, Saint Paul reminds us that because of our faith, we are promised the grace of peace and hope through any difficulty.

SUFFERING

“Suffering produces endurance, and endurance produces character, and character produces hope, and hope does not disappoint us, because God’s love has been poured into our hearts” (Romans 5:3–5). It is difficult to make sense of suffering. For those living with the despair that is associated with mental health afflictions, being reminded to have hope and feel God’s love is easier said than done. For this reason, we cannot just throw out these Scripture passages without being able to offer ministries that concretely offer hope and what it looks like to be God’s love for others.

Parish communities may need to be reminded that with faith and grace we can receive those who live with mental illness with gentleness and “bear one another’s burdens” in a way that defeats the isolation of mental illness and strengthens faith—that of those involved in offering support and the faith of those who are supported (Galatians 6:2).

THE DESERT AND WILDERNESS

Many biblical stories are situated in the wilderness and desert, from the Israelites in the Exodus stories to Christ in the desert, to the travels of Saint Paul. They are stories of abandonment, loneliness, and fear in uncaring and inhospitable environments that

people have no control over. Many people who live with mental illness relate to this kind of experience.

In her book on depression, *Dust in the Blood: A Theology of Life with Depression*, theologian Jessica Coblentz (2022) discuss how wilderness stories offer perspectives on depression and how in these stories, “What God does bestow is presence, and with that presence” the characters in these stories, and those who live with depression and mental health challenges, can gain “the perception of possibilities previously unrecognized.” These stories do not offer pat simple answers about why we wander in the desert and wilderness of depression and mental health challenges, but they recognize that God accompanies us in our struggles.

HOPE AND LIVING IN RELATIONSHIP WITH EACH OTHER

One of the keys to managing mental illness is a supportive community that nourishes a person’s faith in God. Realizing that the joy that comes from our relationship with God and with one another heals us and gives us hope. Throughout the Gospels, Jesus teaches us about healing and restoring people to their rightful place in the community.

- He told us about the Samaritan who helped the man in the ditch when no one else would.
- He taught us compassion when the father welcomed home the prodigal son.
- He taught us that everyone has dignity, and everyone has value.

By following Christ’s call, the call to live in a loving relationship with one another, we can make a difference for those individuals and

families who are suffering alone, isolated by the stigma of their illness or for their feelings they will be judged or misunderstood. For those who are overwhelmed by the crisis they face, our support and outreach can literally mean the difference between hope and despair.

Your Personal Experience

Do not be afraid to occasionally reference your own experience with mental health challenges. You will help normalize the discussion of mental health. Parishioners need to know that everyone faces mental health challenges, including members of the clergy, and that no one is immune or “above” facing mental health challenges. Bishop John Dolan of Phoenix is an exemplary example of a Church leader who speaks effectively about his own experience in a way that offers hope to others. Here is an excerpt from a reflection he offered:

I am a bishop, but before anything else, I am a human being who knows the severities of mental health; especially if untreated. As a survivor of suicide loss, I have witnessed first-hand the pains of mental health in my family. I understand the importance of Catholic Mental Health Ministry and the gift it brings to so many people within our parishes and families.

The truth is, when I had to survive these losses in my life, the Church was the only place of comfort for me. I relied heavily on the prayers and the spiritual outreach of my priests and women religious from my home parish, as well as the priests on staff in the seminary. Mental Health

Ministry maintains the Gospel mandate to tend to those in need. Certainly, those who struggle with depression, anxiety, post trauma, scrupulosity, and OCD (just to name a few disorders) need continuous love and care from the wider Body of Christ.



CHAPTER 12

A PASTORAL APPROACH TO SUICIDE: DISCUSSING THE HARD QUESTIONS AND ACCOMPANYING THE GRIEVING

*MOST REVEREND BISHOP JOHN DOLAN AND DEACON ED
SHOENER*

Priests, deacons, and lay persons in grief ministry are sometimes called to accompany survivors of suicide loss. We are called upon to bring the Light of Christ into their darkness and help guide them to a hope that can only be found in His Resurrection. Our own faith may be challenged by the awful circumstances of suicide and the hard questions some survivors ask of us:

- How will my loved one be judged by God?
- Is my loved one in hell?
- Will my loved one be punished in purgatory?
- Is it possible for my loved one to go to heaven?
- Can I pray for my loved one who died by suicide?
- Can my loved who died by suicide pray for me?

These questions may never actually be spoken in your presence. It may be that a survivor is simply looking for support, consolation, the most basic simple pastoral care, which the Church has come to call accompaniment. Many survivors will simply want a representative of the Church to be there. However, should these questions be asked, it is important to remember some key teachings of the Church on death, judgment, purgatory, heaven, and hell.

Addressing these teachings in times of grief requires humility and compassion on the part of the minister. We stand on holy and sacred ground as we see the suffering Christ in the grieving person who stands before us. We cannot make their pain, grief, and suffering go away. That is not within our power. But the Holy Spirit will work through us we pour the healing balm of Christ's love upon the wounds of survivors of suicide. This spiritual balm is contained, in part, within the teachings of Christ's Church. Christ's mercy flows through these teachings. Coupled with charity, these teachings offer hope in a compassionate Christ who calls us to Himself.

Knowing these teachings will be important, but we should always lift our hearts to God before and during any conversation with a person grieving a suicide. The person before us is deeply wounded. Christ is the Divine Physician. We are not. Yet we are privileged as God's ministers to be in conversation with the grief stricken. Therefore, we should always remember to invite God into our hearts as we let the Holy Spirit guide our conversations.

Eschatology: A Review of the Four Last Things

Our faith tradition considers four last things (eschatology) when we close our eyes on this life: These are death, judgment,

heaven, and hell. According to the *Catechism of the Catholic Church* (or CCC; John Paul II, 1994), “Each man receives his eternal retribution in his immortal soul at the very moment of his death, in a particular judgment that refers his life to Christ: either entrance into the blessedness of Heaven—through purification—or immediate and everlasting damnation” (CCC, Paragraph 1022).

Regarding purification, the Church’s teaching on purgatory in the *Catechism* is short and direct: “All who die in God’s grace and friendship, but still imperfectly purified, are indeed assured of their eternal salvation; but after death they undergo purification, so as to achieve the holiness necessary to enter the joy of heaven” (CCC, Paragraph 1030).

Praying for All Souls

Although the Church does not teach that there is universal salvation, the Church expects the faithful to pray as if all can be saved. The Fatima prayer for Jesus to “lead all souls into heaven, especially those in most need of thy mercy,” or Saint Faustina’s Divine Mercy request that Jesus atone for “our sins and those of the whole world,” are just a few examples of our response to the Lord who Himself prayed “that all may be one” (John 17:21, in Senior et al., 2011).

When a loved one dies by suicide, many wonder how they can show the one who has died that they are still loved. The simple answer is that we pray for them. As we celebrate a Mass or obtain indulgences on their behalf “through works of mercy and charity and by acts of penance,” we offer up the pain of our suffering for those who have gone before us (CCC, Paragraph 1032).

The Church's teaching on purgatory is beautiful and can even be healing for survivors as we pray together for those who have died by suicide. Reciting the following prayer offered at funerals is healing for both the deceased and their survivors:

*Eternal Rest grant unto them, O lord. And let
perpetual light shine upon them.*

May they rest in peace. Amen.

*May their soul and the souls of all the faithful departed
through the mercy of God,
rest in peace. Amen.*

In turn, we trust that those who have gone before us, including those in purgatory, continue to pray for us. Those in the state of purification are in communion with us who live in this world *and* with those who enjoy eternal beatitude in the fullness of heaven. Paragraph 49 of *Lumen Gentium* (Paul VI, 1964) expresses this perfectly:

Until the Lord shall come in His majesty, and all the angels with Him and death being destroyed, all things are subject to Him, some of His disciples are exiles on earth, some having died are purified, and others are in glory beholding “clearly God Himself Triune and One, as He is but all in various ways and degrees are in communion in the same charity of God and neighbor and all sing the same hymn of glory to our God.

Judgment

The nature of purgatory, heaven, and hell are not nearly as important for us as the questions of how we will be judged and who will do the judging. As Catholics, the answer is simple. All of humanity will, in a particular and then a universal way, stand before the judgment seat of Jesus Christ, who is our Judge. Matthew 25 gives us a glimpse of the judge who will separate us, as a shepherd separates sheep from goats (Senior et al., 2011).

If we live and die faithfully and lovingly in Christ, we have a moral assurance that we will be judged mercifully and that heaven will be our reward. If we refuse to live faithfully and lovingly in Christ, Scripture refers to those who will be judged harshly and will be found in hell. There is simply, death, judgment, hell, or purgatory and heaven.

What is not found in the *Catechism* (John Paul II, 1994), nor in sacred Scripture, nor in the Tradition of the Church is a permission for us to usurp the role of Christ Jesus and become the judge of the dead. This belongs to Christ and the mercy of God alone. Mercy is generously poured out upon all of humanity because we are a sinful people. We are a people who live in a realm of concupiscence and, being forever tempted, we are apt to sin.

The Roman Catholic Church teaches that from the moment sin entered the world, God began a plan of redemption. “Oh happy fault! Oh necessary sin of Adam, which gained for us so great a redeemer” (from the *Exultet* at the Easter Vigil in *Roman Missal*, 2011). Covenant after covenant, from Adam, through Noah, Abraham, Moses, King David, the Prophets, and to and through

Christ Jesus, God revealed His mercy. Blessedly, God's mercy is unmerited.

Scattered through the pages of history, human beings showed glimpses of true virtue and fidelity. Of course, the same pages show a human world of vice and downright evil. We are physical beings with souls of intellect and free will who were made in the image and likeness of God. This is a starting point for understanding our uniqueness in all of God's visible and invisible Creation. Yet we are tempted and inclined to sin (concupiscence); we willfully succumb to sin and veer away from the will of God. Our conscience, on the other hand, urges us to remain with God and to live virtuous lives. On a very basic level, this *doctrine of humanity* is the Church's teaching of our human condition.

However, a development of the doctrine on the dignity of the human person acknowledges concupiscence as something more than just a rational or willful choosing of vice versus virtue. An understanding of the doctrine of the human person must recall this reality that the sciences of psychology and psychiatry continue to provide. Whether through chemical, biological, or situational realities (post trauma, childhood abuse, drug dependent homes, etc.), many of us do not in fact freely and willfully choose to abandon God or human virtues. Due to these situations, there is some lack of culpability or blameworthiness. In the case of those who have died through suicide, this understanding of our human nature must always be considered.

A Compassionate Pastoral Response to Suicide

In 2018, the bishops of California issued a pastoral letter titled *Hope and Healing*, on caring for those who suffer from mental illness. In this pastoral letter, the bishops addressed the issue of suicide, which is so often associated with mental illness. This letter provides authoritative pastoral guidance to Catholic leaders on the attitude that ministers should have when they minister to people who are grieving a suicide. The section on suicide from the pastoral letter is as follows:

We, the bishops, would like to address the heartbreaking tragedy of suicide, particularly among those who are young, and offer a word of consolation to the many people who have lost a loved one to suicide. Sadly, suicide is now the second leading cause of death among adolescents and young adults, and the tenth leading cause of death overall in the United States, accounting for more than 42,000 deaths per year. Behind each of these staggering numbers are families that have been deeply impacted and forever changed. We know that most deaths by suicide are associated with a severe mental illness, such as major depression, schizophrenia, or bipolar illness. Those who have lost a loved one to suicide—as well as those whose loved ones are homeless or imprisoned as a result of mental illness—suffer especially painful wounds and are particularly in need of our compassion and support. For reasons that are beyond our comprehension, some individuals suffer from serious mental illnesses that prove

difficult to treat or impossible to cure. Such illnesses can affect not just a person's moods and emotions, they can also constrict a person's thinking—even to the point where the person feels entirely trapped and cannot see any way out of his or her mental anguish. Mental illness can impair a person's capacity to reason clearly; it can adversely impact sound judgment, such that a person suffering in this way is liable to do things, which, when not sick, he or she would never consider. Tragically, in spite of our best efforts to assist the suffering person, sometimes mental illness proves fatal.

While the Church teaches that suicide is contrary to the will of God who gave us life, at the same time, the Church recognizes that “grave psychological disturbances, anguish, or grave fear of hardship, suffering, or torture can diminish the responsibility of the one committing suicide.” The *Catechism of the Catholic Church* goes on to instruct us that “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.

Those who lose a loved one to suicide need particular care and attention, often for considerable periods of time. They have not only lost someone dear to them and are deeply grieving, their intense grief is often complicated by feelings of shame, confusion, anger, or guilt. They may replay in their minds their last conversation with the loved one and wonder whether they could have done more to prevent the

tragic death. Furthermore, they often feel alone and misunderstood, as though they cannot discuss this with anyone. Catholics must convey to them that we are not afraid to open this difficult conversation, that they need not feel ashamed to discuss their profound anguish and loss. While healing in these situations happens only very slowly, we must be willing to walk this long road with suicide survivors, to help console them with our unconditional friendship and with sensitive pastoral care. In closing, let us remember that Christ's heart—a heart both human and divine—is merciful beyond measure. It is here that we place our hope. It is into Christ's hands stretched out on the Cross that we entrust our loved ones who are suffering and all who have died as a result of a mental illness. We pray that the departed may find God's peace, a peace that surpasses all understanding. We pray that the angels will one day welcome them to that place where their grief will be extinguished, where they will suffer no more.

Avoiding Three Forms of Judgment

If, as the California bishops proclaimed, God's mercy is "beyond measure," then we must approach suicide with mercy as well. As ministers, we should avoid three things when addressing suicide, namely a tendency to be overly judgmental, overly psycho-analytical, and overly spiritual.

A real-life example of a priest who accused parents of aiding in their son's suicide because they had not brought him to weekly Mass

points to a serious lack of charity and bad judgment. Another case involved a deacon who asked a grieving family if he could find a priest to offer an exorcism for their son's bedroom, which shows an example of judging through over-spiritualizing the suicide.

Suicide is a very complex matter and a simple answer as to why a person would take their own life is often a mystery that cannot be explained by faith or reason. Nevertheless, there is a tendency for priests and ministers to weigh in on the matter and try to provide answers. Often, it is simply best to listen to and prayerfully support those who are grieving a suicide and not attempt to offer reasons for the tragedy.

AVOIDING JUDGMENT

As we consider the act of suicide, we must be reminded that that one act cannot define the level of fidelity that the person who died by suicide had in his or her life. There are many charitable, loving, and faithful souls who are also lost in a world of psychological oppression. It is our prayer that God does not judge us by a singular act, but rather on our general and fundamental stance in life.

Whether or not the person who jumps from a bridge cry out at the last moment to God for mercy, God understands the nature of that person. It would be rare that a person who died by suicide did so by acting with his or her full use of intellect and free will. It is also an oversimplification to assume that a suicidal person has a lack of faith in God. As pointed out earlier, the development of the doctrine on the dignity of the human person allows the sciences of psychology and psychiatry to weigh in on each person's level of culpability; even while that person seeks a right relationship with our loving God.

This isn't to say that we are not called to be virtuous people. Christianity demands a carrying of the cross daily, an exercise of faith, and a life of charity. However, simply put, some people, due to their psychological makeup, life circumstances, and other factors, are more equipped to be virtuous than others.

Suicide is clearly different from death through natural or accidental causes. The Church will forever say it is never right to end one's own life. The act of suicide, in and of itself, is a grave matter. The act, however, is one thing; the intention and the circumstances that lead up to that act is another. When a person who has bipolar disorder, schizophrenia, or is post-traumatically disordered, ends their own life, it is assumed that they were not of the right mind to willfully act against our common and basic human instinct to live. This does not dismiss the gravity of the act itself. In fact, it is sinful in that it "misses the mark" (a Greek expression for sin) of what it means to live and love happily with God, with others, and with oneself. But it certainly puts things into perspective if we are inclined to pass judgment on suicidal persons.

As discussed in other chapters in this book, suicide was once judged by many in the Church based purely on the act itself. For this reason, a person who died by suicide was not permitted a Christian burial. Today, Christian burial is not only encouraged but expected as the Church responds to suicide with a new level of compassion based on our understanding of the psychological complexities of the human mind.

AVOIDING AMATEUR PSYCHOANALYSIS AND TREATMENT

Often, when family members approach a parish for a funeral of a loved one who has died by suicide, the pastor or bereavement ministers will try to offer additional support through one-on-one or grief support group sessions.

Invariably, sessions will include some conversations about the decedent's history of mental health. In some cases, it is revealed that there were no signs at all that the person was ever suicidal. For some pastors or bereavement ministers, there is a tendency to try to answer the reason for suicide by psychoanalyzing the situation.

This too can be a form of judgment. Although it is not an attempt to judge the soul, it is an attempt to fix or clean up the mystery of death by suicide. Walking the family through the mystery of death as it relates to the mystery of the Cross is one important element of the pastoral care of the grieving. But it is not the place of a pastor or parish minister to delve into the fields of psychology and psychiatry and attempt to offer a post-mortem psychological diagnosis to explain why a person died by suicide.

Parish ministers are meant to accompany individuals and their families who are grieving suicide, not to offer psychological counseling or therapy. Pope Francis often uses the word "accompaniment"; accompaniment simply requires an atmosphere of prayer, presence, and peace. Accompaniment gives those who are grieving a suicide an avenue to talk about their feeling and emotions, and because of this some knowledge of psychological dysfunction, addiction, and mental illness is crucial to becoming a loving support to those who grieve one who died by suicide.

Stepping beyond the zone of accompaniment and into the world of psychoanalysis and treatment not only puts the clergy member or Catholic mental health minister in a place of legal liability, but may hamper persons who are struggling with depression or complicated grief from seeking professional help. In fact, parishes should obtain a list of psychologists and grief counselors who have verified licenses to assist parishioners. These lists may be obtained from county social agencies or from a local Catholic Charities office.

Avoiding Over-Spiritualizing

As is the case of some ministers who psychoanalyze a suicidal event, there is a tendency for ministers to over-spiritualize suicide. The real-life case about the deacon who asked a family if they would like to have a priest exorcise their home after the suicide of their loved one is an example of over-spiritualizing an event.

Some priests and ministers seem to find the devil around every corner and think that prayers of exorcism or deliverance will address the cause of strife in a person's life. When it comes to depression, suicide, or attending to survivors of suicide loss, such over-spiritualization is not helpful and may actually be harmful.

In a way, similar to psychoanalyzing the cause of suicide, suggesting that "the devil made them do it," by over-spiritualizing the event, is a form of judgment. Again, it may not be judging the person per se, but attempting to solve the mystery of suicide prematurely. It does a disservice to the field of psychology which, we are convinced, is Spirit driven.

FIND THE RIGHT BALANCE

Our Church recognizes and celebrates that the two disciplines of faith and science as having the same end. Faith and science lead us to God. They go hand in hand, and they are perfectly balanced. As ministers, we are encouraged to keep them in balance when we offer spiritual support. To either over-psychoanalyze or over-spiritualize a suicidal event tilts the balance, and someone suffers unnecessarily.

Offering prayerful support through accompaniment is the first step that should be adopted by Catholic leaders when addressing survivors of suicide loss or people who may be depressed. The second is to refer those affected by depression or complicated grief to mental health professionals. Having a list of professional counselors at hand is always helpful.

As priests and ministers, judging a suicidal person's soul, or judging the act of suicide itself does not belong to us. Rather, we are asked to entrust to the Lord those who have died by suicide and ask the Merciful Judge to grant them eternal rest. As Pope Francis once said in a Lenten homily about those who have died by suicide, "To the very end, to the very end, there is the mercy of God" (2019).

In the end, we are called to be merciful as Christ is merciful, to entrust the souls of the faithful departed to God, and to accompany those who grieve, including survivors of suicide loss.

KEY POINTS

- To accompany a person who is grieving the death of a loved by suicide requires you to be with them in the darkness of grief. You may be asked hard questions about “the four last things.” Again, these are death, judgment, heaven, and hell.
- Christ’s mercy flows through the teachings of the Church. These teachings can heal those who are grieving a suicide with the promise of ~~the~~ resurrection.
- Purification can be found in purgatory. Christ will offer His mercy to purify a person of all that led to their death by suicide. We must pray for the souls in purgatory.
- Pope Francis said about those who have died by suicide, “To the very end, to the very end, there is the mercy of God.”
- We must be willing to walk the long road to healing with suicide survivors, to help console them with our unconditional friendship and with sensitive pastoral care.
- As ministers, we should avoid three things when addressing suicide: namely, a tendency to be overly judgmental, overly psychoanalytic, and overly spiritual. We must find the right balance.

REFLECTION

1. How will I discuss the question “Is my loved one in hell” with a person who is grieving a death by suicide?
2. Am I spiritually and emotionally prepared to accompany a person who is grieving a death by suicide?

3. How can I use the teaching on purgatory to help a person grieve a suicide? What spiritual practices might I suggest?
4. Beyond preparing for the funeral, what can my parish or community do to “walk the long road” with individuals and families who are grieving a suicide?



CHAPTER 13

MENTAL HEALTH MINISTER SELF-CARE

JENNIFER HOUSEL

Dear Lord, help me to hear what You may be bringing to my attention today. Allow me to breathe in Your Spirit and to be inspired and strengthened to do Your will.

Sometimes when I am working in ministry, spending my time on self-care can be a significant challenge. Help me to know the wisdom of Your gift of the Sabbath, and so to incorporate restful self-care practices into my everyday life. This, so that I may better serve You through better serving Your children who live with mental health challenges and those who care for them.

I ask this in Christ's name. Amen.

Fulfilling the Mission of the Church

In offering service in mental health ministry, ministers are working to fulfill the overall mission of the Church. Mental health ministers are missionaries, called and sent to share Christ's love, mercy, and care to those affected by mental illness.

Pope Francis describes that the Christian Catholic's call to serve is not for the faint of heart but is rather a bold commission and a solemn responsibility. In his apostolic letter *Maximum Illud*, Pope Francis writes about "a sense of duty towards the missions ..." which "is a response to Jesus's perennial command to 'go into the whole world and proclaim the Gospel to every creature' (Mark 16:15)." He goes on to state, "Obeying this mandate of the Lord is not an option for the Church ... it is her 'essential task,' for the Church is 'missionary by nature.' ... If the Church is to remain faithful to herself and to preach Jesus crucified and risen for all, ... then 'prompted by the Holy Spirit, she must walk the same path Christ walked: a path of poverty and obedience, of service and self-sacrifice.' In this way, she will effectively proclaim the Lord, 'model of that redeemed humanity, imbued with brotherly love, sincerity and a peaceful spirit, to which all aspire'" (Francis, 2017).

Mental health ministry calls for ministers to enter into the lives of, and to walk alongside, people in some of the most challenging experiences of their lives. This ministry requires much from those who serve within it, and, because of the nature of this mission, it is possible for mental health ministers to experience burnout and spiritual fatigue as a result of this work. Regularly practicing good self-care can help protect ministers from this spiritual fatigue or burnout.

Need for Self-Care

Many people serving in mental health ministry have experienced mental health challenges, whether their own and/or among their family and friends. These experiences can help bring a real-life perspective and beautiful empathy to the ministry. Ministers with these additional challenges are invited to be especially conscious of the need for awareness of their internal equilibrium and to regularly practice good self-care. Particularly when planning to approach your parish leadership about beginning a mental health ministry, first take stock of your own spiritual, mental, and emotional health. This is the recommendation whether you personally experience mental illness or not.

For a variety of reasons, your parish leadership may not welcome a mental health ministry. There may be a real or perceived lack of resources for a ministry in your community, and fear, stigma, and ignorance around mental illness still exist. Plan for practicing good self-care and be sure you have a circle of support in case you receive a negative response. Not receiving permission to bring a mental health ministry to your community can be a painful disappointment, so be prepared to work through and process a potential negative response.

Caring for oneself in balance with caring for others is so essential, particularly when accompanying those with mental health challenges, that Mental Health First Aid Training addresses self-care as one of the main components in its training content, requiring participants to complete a Self-Care Plan as part of the training (MHFA, n.d.). The topic and practice of self-care must be a regular focus for those serving in mental health ministry.

PERIODS OF REFUGE

Sabbath: Finding Rest, Renewal, and Delight in Our Busy Lives (Muller, 1999) is a book written by Wayne Muller that explores the need for periods of refuge in the midst of living and serving in a mission-driven life. In *Sabbath*, Muller teaches about the pervasive and destructive busyness of modern life and how a return to the practice of Sabbath rest can help ministers to prioritize self-care.

Muller writes this about the people that he meets in his work, many of whom are in ministry, “Whether they are Hispanic or Native American, Caucasian, or Black, the more their lives speed up, the more they feel hurt, frightened, and isolated. Despite their good hearts and equally good intentions, their work in the world rarely feels light, pleasant, or healing. Instead, as it all piles endlessly upon itself, the whole experience of being alive begins to melt into one enormous obligation. It has become the standard greeting everywhere: *I am so busy*” (Muller, 1999, p. 2).

This intense drive toward constant productive activity is endemic; it crosses from the secular world into our faith communities, and it can have startling consequences. Muller, through his work with people suffering with AIDS, cancer, and other life-threatening illnesses, was regularly struck by the mixture of sadness and relief these people experienced in their illness. He writes, “While each shares their particular fears and sorrows, almost every one confesses some secret gratefulness. ‘Finally,’ they say, ‘at last, I can rest’” (Muller, 1999, p. 20).

Our culture of relentless busyness has escalated to the point where some people feel a sense of relief in the case of their own life-threatening illness because they finally feel they have a *worthy excuse*

to rest, rest that has been profoundly lacking up to this point. Oftentimes, it is this lack of rest that may have contributed toward this person's health crisis. Muller recounts stories of heart disease, extreme exhaustion, and other illnesses that finally awakened people to recognize their critical need for regular periods of rest in their lives.

This hectic and stressful pace of life is not what God wants for us. God cares for us more than any earthly parent could. (USCCB, n.d.; Matthew 7:9-11; Isaiah 49:15) But it is our responsibility to give Him our time, the pause during which He can replenish us.

In addition to God caring for and wanting the best for us, if a minister reaches this point of exhaustion, burnout, or spiritual fatigue, he or she is unable to serve others. God commands us to love our neighbor as we love ourselves (USCCB, n.d.; Matthew 22:37-39). We must care for ourselves if we are to care for others.

It may be helpful to think about whether you experience a lack of rest, a lack of self-care, in your own life and in your own ministry work. One of the foundational components of self-care is taking the time and making the effort to check-in with ourselves, monitoring our interior physical, spiritual, and emotional equilibrium.

NEED FOR REST

Unsurprisingly, God knows of our need for rest. He is our Creator. God designed much of Creation with a need for regular periods of rest: consider bears hibernating or agricultural fields that periodically lie fallow to regenerate fertile soil. Periods of rest are so essential to our well-being that God gave us a commandment to keep the Sabbath holy.

Though some have retained the life-giving aspect of this commandment by participating in weekly Mass, many have largely forgotten the meaning of the Sabbath as it pertains to rest. This is not to denigrate the importance of Mass and the Eucharist—these are the foundation, the pinnacle, the keystone of our Catholic faith. But most of us need more than one hour at Mass to fully experience Sabbath rest.

Muller writes, “Sabbath is a way of being in time where we remember who we are, remember what we know, and taste the gifts of spirit and eternity ... Sabbath is a time for sacred rest...” (Muller, 1999, pp. 6–7). Mass on our Sabbath is better seen as the foundation of a more prolonged and complete sinking into restful replenishment from the Lord. Consider how you keep holy the Sabbath Day. In addition to Mass, do you factor in a period(s) of rest? If you do not necessarily factor rest into your “Sabbath Day,” do you insert periods of rest into other days of the week?

Muller writes, “While many of us are terribly weary, we have come to associate tremendous guilt and shame with taking time to rest. Sabbath gives us permission; it commands us to stop” (Muller, 1999, p. 8). Have you seen examples of Muller’s assertion about guilt and shame within yourself or in your peers in ministry? As mental health ministers, it is vital that we incorporate self-care into our lives as a virtuous practice, and not view it as self-indulgence or selfishness.

Muller reminds us that the Sabbath “gives permission ... commands us to stop,” and this can be a powerful encouragement in setting a goal of regular self-care (Muller, 1999, p. 8). It can be helpful to also remember that even God rested on the seventh day and Jesus too left ministering to the crowds to go away to a quiet place for prayer and rest (USCCB, n.d.; Genesis 2:2–3; Mark 6:31–32).

HOW CAN I HELP?

Think about how ministers may present in ministry when they have taken the time to practice restful self-care. Katie Prejean McGrady challenges ministers to try to bring one question to all ministry interactions, “How can I help?” (McGrady, 2019).

Contrast that question with what is too often a typical reply, “I’m really busy, but what do you need?” Think about from which type of interior space each of these responses arises. Which of these responses accurately communicates God’s timeless love and care?

Especially in mental health ministry, this is the question ministers ask of those they serve: “How can I help?” Ministers must be thoroughly cognizant of their own capabilities and of their own boundaries (and the boundaries inherent in mental health ministry) when they ask this question *and* when they respond to what is shared.

Practicing good self-care in their own lives, taking the time to engage in Sabbath rest, helps mental health ministers to ask this question with the greatest love, and address the needs expressed in the most thoughtful and appropriate ways. Mental health ministers are most able to respond appropriately to their role and to this ministry when they have taken the time to practice self-care.

Building Rest and Self-Care into Life

The following list is meant to serve as a starting place to assist mental health ministers in gathering some ideas about how to build restful Sabbath time and self-care into their lives. Some suggestions are found throughout Muller’s book, and other options are listed as well.

Breathe: Any action that allows one to pause and (at least) figuratively step back from activity and busyness can act as a mini-Sabbath. Consider using a sound, an object, or an activity that occurs many times in your life each day ... as a reminder to take three full, deep breaths. It can be surprising how this simple practice can help to rebalance one's perspective throughout the day (Muller, 1999, p. 39). (It is no coincidence that the Holy Spirit is sometimes referred to as the Breath of God.)

Make something(s) off-limits: As a way to enter into a Sabbath period, "Choose at least one heavily used appliance or device ... and let them rest ... surrender to a quality of time when you will not be disturbed, seduced, or responsive to what our technologies have to offer" (Muller, 1999, pp. 27–28).

Spend time outside: Muller writes, "The Sabbath was born with the creation of the earth, so Sabbath time beats in intimate synchronicity with the rhythms of nature. Set aside a period of time, alone or with someone close to you, and walk, bike, sail, nap—anything that allows your body to be soothed by the enfolding nourishment of the earth..." (Muller, 1999, p. 81).

Pray: Those heavily involved in ministry sometimes become so burned out from their constant experience of church *work* that they neglect their personal prayer lives. However, prayer is a cornerstone of both ministry and of our self-care.

Muller writes, “Prayer is like a portable Sabbath, when we close our eyes for just a moment and let the mind rest in the heart ... [Consider praying] something close to the heart, and simple. Perhaps a line from the Twenty-Third Psalm, the Lord’s Prayer ... Traditional Sabbaths are filled with prayers. But we can begin slowly, with a simple prayer, like a pebble dropped into the middle of our day, rippling out over the surface of our life” (Muller, 1999, pp. 86–87).

FOLLOW THE SCIENCE

Scientific research has revealed much about which practices help people to incorporate good self-care. News headlines regularly offer articles focused on helpful self-care habits. For Catholics, God and the Church have also taught about the importance and necessity of attending to our own revitalization.

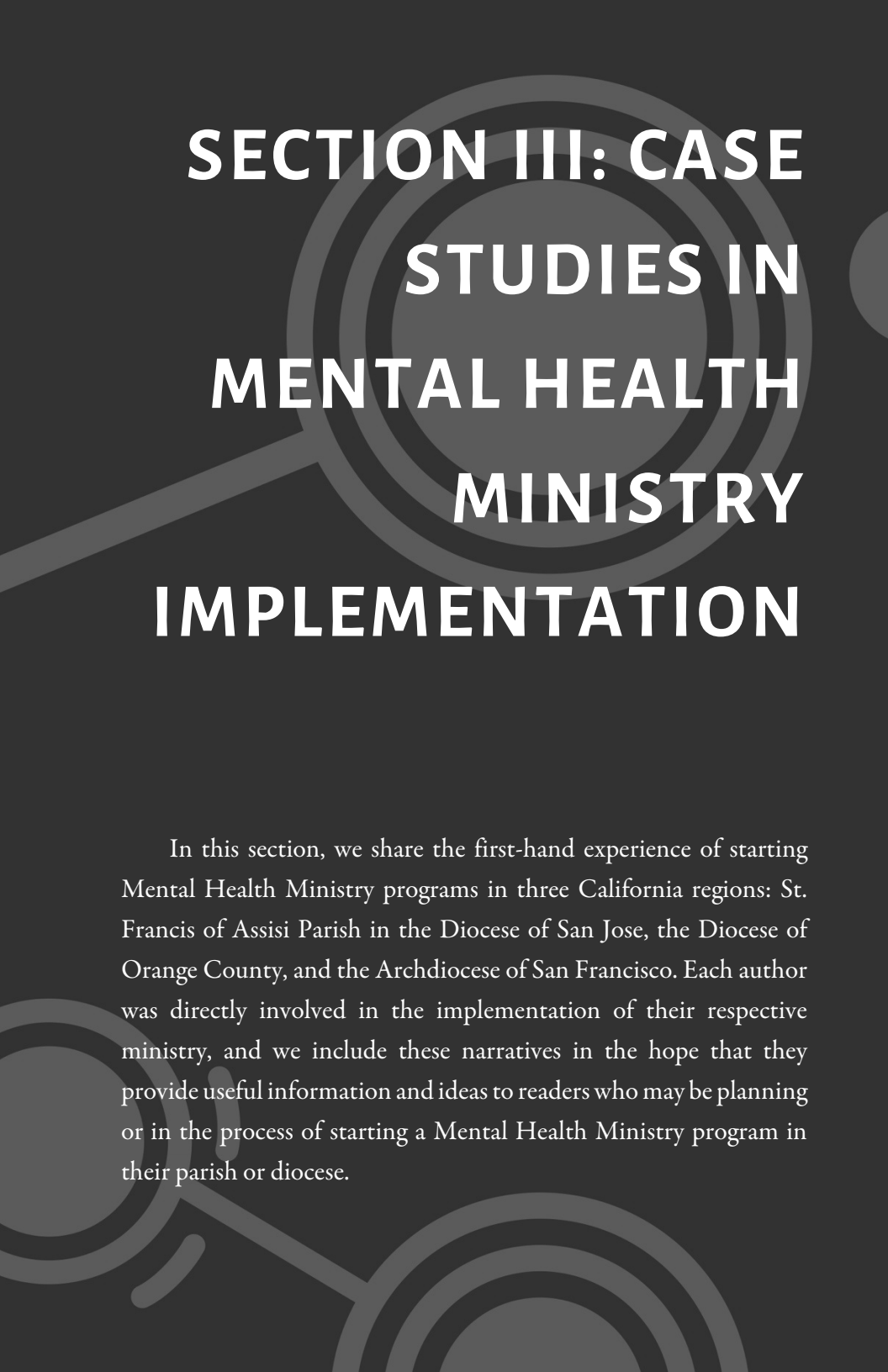
Every person will likely benefit from the self-care suggestions found at the top of the list that follows; these are drawn from commonly known and accepted practices. Many will find that they can also benefit from those suggestions found nearer to the bottom of the list.

- Healthy sleep habits
- Good nutrition
- Positive relationships
- Meaningful and interesting daily tasks
- Movement and physical fitness
- Prayer and Sabbath rest time
- Spiritual Direction
- Spiritual Retreats
- Support groups

- Counseling/Therapy

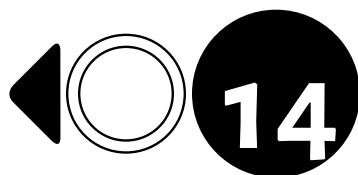
REFLECTION

1. How do I find it difficult to reflect the face of Jesus to others, to serve well in my role as a mental health minister, when I am tired or stressed?
2. How would my mental health ministry service be affected if I were to build more Sabbath rest time into my life, incorporating more self-care practices by using some of the options listed?
3. How will I be able to react in a healthy way if my desires for a mental health ministry program in my community are met with possible obstacles and negative responses? What supports can I put into place in my own life, to help me to care for myself if I must navigate challenges as a mental health minister?

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SECTION III: CASE STUDIES IN MENTAL HEALTH MINISTRY IMPLEMENTATION

In this section, we share the first-hand experience of starting Mental Health Ministry programs in three California regions: St. Francis of Assisi Parish in the Diocese of San Jose, the Diocese of Orange County, and the Archdiocese of San Francisco. Each author was directly involved in the implementation of their respective ministry, and we include these narratives in the hope that they provide useful information and ideas to readers who may be planning or in the process of starting a Mental Health Ministry program in their parish or diocese.



CHAPTER 14

3 GEN+ MENTAL HEALTH MINISTRY AT ST. FRANCIS OF ASSISI CHURCH, SAN JOSE, CA

BARBARA ZAHNER

*An elderly parishioner confided he felt he burdened
his family.*

A teen shared she felt unheard by her parents.

*A middle-aged immigrant met with his pastor. In
strident tones, he described his anger with his wife, his
sons, and his boss. He drank too much, drove too fast,
and slept too long. Now his boss had threatened to
terminate him for poor performance.*

The plight and anguish of these three parishioners of St. Francis of Assisi Church in San Jose birthed 3GEN+ Mental Health Ministry. Our original goal focused on three generations: teens, parents, and seniors. Then we realized we needed to minister to all. We called our Mental Health Ministry 3GEN+—three generations PLUS all others. Eventually the “all others” embraced seven other

parishes in the Diocese of San Jose and three other California dioceses.

Surrounded by green hills and bordered by a vineyard of lush Zinfandel grapes, St. Francis of Assisi sits atop a hill overlooking Santa Clara Valley, originally called the Valley of Heart's Delight. In more recent times, it is known worldwide as Silicon Valley, the home of entrepreneurs, innovation, and a dizzying background of cultures. Unlike most regions in our country, Santa Clara County has no racial majority. The area is comprised of one-thirds: 1/3 Asian-Pacific Islander (API), 1/3 Hispanic, and 1/3 Caucasian. The Black population represents 2 percent of the total county census. St. Francis of Assisi Parish reflects a similar cultural mix. Those parishioners who self-identify as API comprise primarily Filipino, Vietnamese, and Indian. The majority of Hispanic parishioners are rooted in Mexico. The parish includes a 55+ gated community. As a result, many of the White population are seniors. The Asian and Hispanic families are younger than the White parishioners, many of whom are widows or widowers. St. Francis of Assisi parishioners support the parish wholeheartedly with time, talent, and treasure. They take their financial obligations seriously; they consistently surpass the goal for contributions to the Diocesan Annual Assessment. They also contribute to the parish revenue by buying niches in the Memorial Garden as extended family, so the family can continue to "stay together" even in death. In addition, the family can visit the graves of loved ones after Mass. The Vietnamese families especially follow the custom of buying niches for the extended family in the Parish Memorial Garden.

Teams

Father Matt Stanley, pastor of St. Francis of Assisi Parish, created our original Mental Health Ministry Team of seven. They included three staff members: Lisa Sabin Nakamura, director of Faith Formation; Cecile Vo, director of Social Justice; Kevin Bernaga, director of Youth and Young Adult Ministry; plus two volunteers: Diane Haaser, Homebound Minister; and Barbara Zahner, 3GEN+ Mental Health Minister. In addition, two of our three parish priests joined our Mental Health Ministry Core Team: Fr. Matt and Fr. Michael Syjueco, Parochial Vicar. As changes occurred, two other team members joined our 3GEN+ Core Team: staff member Maleny Quiroz Hernandez, coordinator of Hispanic Ministry; and Richard Zahner, who had joined his wife Barbara in the 2019 training in San Diego. Because of Rich's professional background, he served as our contract administrator for the three-year grant period.

As a synchronicity, our original team encapsulated the demographics of St. Francis of Assisi Parish: Asian-Pacific Islander, Hispanic, and Caucasian. While none of us considered ourselves spokespersons for our culture, as part of our team formation we honestly disclosed our journeys in mental health from the lenses of our respective cultures. Frequently in our mutual exchange, we shared laughter and tender "ah-has" as we heard each other's story. This mutual self-disclosure and shared lived experience provided fertile ground to build our Mental Health Ministry program as we moved through three phases in three years: 1) Parish Planting, 2) Pandemic, and 3) Propagation.

Phase 1: Parish Planting, 2019

In Phase 1, the *Parish Planting* of our Mental Health Ministry, the three staff members, two volunteers, and Fr. Michael and Fr. Matt formed our team. Having Pastor Fr. Matt volunteering to serve on the Core Team boosted our team's sense of vitality and importance in the parish life and priorities of St. Francis of Assisi Church. Before our initial Catholic Institute of Mental Health Ministry (CIMHM) training in San Diego, our team:

- Wrestled with the grant goals and timeline. How to translate lofty words to concrete, doable actions?
- Created a logo for 3GEN+ for “brand recognition” in the parish bulletin, social media, and posters to publicize events.
- Wrote and practiced an “elevator pitch” to capture the mission and praxis of Mental Health Ministry at St. Francis of Assisi Church.
- Presented to the Mental Health Ministry at our Deanery 6 meeting.
- Arranged to engage in the CIMHM week-end training held Feb 21–24, 2019, in San Diego.

GET IN THE BOAT WITH JESUS

In truth, the CIMHM training frayed our team cohesion. One member wrote an email stating parish responsibility interfered with continued participation. In essence, “Count me out.” Another commented that the Mental Health Ministry would overwhelm the parish. A third, invigorated by the training in San Diego, desired to quit church ministry and become a therapist. At our first meeting after our training at the University of San Diego, we riffled through

our spiral-bound manuals, *Catholic Mental Health Ministry: Guidelines for Implementation*. Sighing, we expressed trepidation about where to begin. Looking back now, I observe that fear nearly swamped our Mental Health Ministry launch. As an inexperienced Mental Health Ministry coordinator and new to the parish, I floundered in leading. Praying for wisdom, I asked our beleaguered team, “What would Jesus say?” After a tsunami of silence, Lisa Nakamura responded, “Get in the boat.” Those six words became our mantra—“*Get in the Boat with Jesus.*”

ONGOING TEAM TRAINING, 2019

As part of our own formation in Mental Health Ministry we:

- Discussed Chapters 1–5 in *Catholic Mental Health Ministry: Guidelines for Implementation*.
- Reflected on *Hope and Healing: A Pastoral Letter from the Bishops of California on Caring for Those Who Suffer from Mental Illness*
- Considered liturgical ideas from *Welcome and Valued: Building Faith Communities of Support and Hope with People with Mental Illness and Their Families*, published by National Catholic Partnership on Disability (NCPD), Washington, DC.
- Invited speakers from the National Alliance on Mental Illness (NAMI) Santa Clara County to present to our parishioners *In Our Own Voices and Breaking the Silence*.
- Screened the film *Angst* on teen anxiety and followed it with an interactive panel discussion with mental health professionals. The panel included a child and adolescent psychiatrist, two school counselors (one from a public high school and the other from a Catholic girls’ academy), a

therapist whose son had died from suicide, an original 3GEN+ Team Member, and Fr. Michael Syjuco.

- Created a Taizé prayer service in October 2019, using the words from the California Catholic Conference of Bishops pastoral letter *Hope and Healing* as part of the liturgy. In addition, two parish members, one Cambodian and the other Mexican, shared their stories of mental illness in their lives and how their faith and the Church strengthened them to continue—despite their daily pain. As the prayer service began, parishioners sat far apart in the pews. They stared straight ahead, avoiding eye contact. By the end of the 40-minute liturgy, parishioners walked out together, marveling at how God had touched them by naming their pain and acknowledging their shame, anger, and inner chaos. Then, miracle of miracles, they realized that they were not alone. Amazing Grace!

Phase II: Pandemic 2020, Fill the White Space!

On March 8, 2020, we found taped to the church doors an ominous notice: “In response to COVID-19, the church is closed.” In March 2020, Catholic churches in the Diocese of San Jose shuttered. Instead, we worshiped via Zoom, a technology created by a company headquartered in San Jose. Since 2020, COVID-19 has killed nearly 1 million Americans. Millions more are still living amid fear of sickness and death, experiencing increased anxiety, depression, burnout, and suicidal ideation. Isolation, loneliness, and a soul-searing lack of certitude tear at our psyche. Teenagers particularly suffer mental and emotional fragility.

At St. Francis of Assisi, the usually bustling parish campus remained silent throughout the pandemic shutdown. No preschoolers clambering on the play structure. In our Respite Center, no white-haired parishioner diagnosed with Alzheimer's sang pop tunes from the '40s and '50s. Our parish paper bulletin converted to online weekly editions. One problem. No parish news. No events. No celebrations. No special Marian liturgies to honor a feast of the Blessed Mother accompanied by music in Tagalog, Spanish, Igbo, Hindi, Vietnamese, or English.

As 3GEN+ coordinator, I offered to our pastor Fr. Matt Stanley to write bulletin articles on mental health. With a sigh, Fr. Matt responded, "Go ahead. Write as much as you want. We have no news." Fr. Matt's comment sparked a year with a rare education opportunity—unlimited space in the parish bulletin to cover the intersection of faith, spirituality, and mental health. My computer files labeled "Sunday Bulletins" now holds almost 70 articles on "Emotional, Mental and Spiritual Well-Being in the Light of Faith in the Dark Times of COVID." To my joy, occasionally a parishioner or staff member would respond to a 3GEN+ column.

Then another unexpected blessing manifested. Fr. Matt and other staff members referred parishioners to me for spiritual accompaniment. With masks in place and practicing social distancing, these parishioners and I navigated the distress of COVID. By simply walking up and down and through the parish vineyard, I literally stepped side-by-side in listening presence with those in distress. Like writing the bulletin articles, this spiritual companionship offered me a rich practicum and profound formation in Mental Health Ministry and, eventually, as Mental Health Ministry Mentor.

On the other hand, our Mental Health Ministry Core Team ceased meeting face-to-face. We moved to Zoom check-ins. Eventually, even these ceased. Kevin Bernaga and Lisa Nakamura continued their connections with youth, teens, and parents in the sacramental programs. Barbara stayed in touch with the elderly through a prayer group that continued to meet via Zoom during the pandemic. Uncertain of the impact of the pandemic on their finances, St. Francis of Assisi Parish reduced staff. This loss affected the morale of both staff and parishioners.

In addition, the Diocese of San Jose significantly cut staff. In April 2020, the director of the Office of Life, Justice, and Peace who oversaw the Mental Health Ministry program left as result of the diocesan reduction in force. Then Fr. Dan Urcia said “Yes” to Bishop Oscar Cantu’s request that Fr. Dan oversee the Office of Life, Justice, and Peace. With COVID clampdowns, Fr. Dan’s primary ministry in the jails. Fr. Dan Urcia’s arrival meant that the Mental Health Ministry program in the Diocese of San Jose welcomed its ninth director for Social Justice in five years. Each director offered a different perspective in the position. Fr. Dan provided non-judgmental availability and heart-felt encouragement. In my experience, these two qualities personify a Mental Health Minister. They also offered those of us in Mental Health Ministry a sense of stability amid widespread uncertainty.

Phase III: Propagation 2021

In 2021, we launched Phase III of Parish-Based Mental Health Ministry in the Diocese of San Jose—Pollination. In 2018, when we applied for the CIMHM grant, we wrote one line for Year Three:

“Parish hosts ‘how to implement 3GEN+’ for San Francisco, San Jose, Monterey, and Stockton Dioceses Faith Formation Conference.” In 2018, our Year 3 goal had no feet. In 2021, it trod a different path. The anticipated Faith Formation Conference fell victim to a Pandemic Church—reduced in scope and restricted to Zoom. However, the Association of Catholic Mental Health Ministers (ACMHM), under the vision and leadership of Deacon Ed Shoener of Scranton, PA, offered direction.

In 2021 in its first round of grants, the ACMHM provided seed money to seven parishes in the Diocese of San Jose to plant Mental Health Ministry programs in each parish. These parishes were: Holy Spirit, Santa Teresa of Avila, St. Lucy, St. Nicholas–St. William, St. Simon, St. Thomas of Canterbury, and St. Francis of Assisi. With St. Francis of Assisi Parish as the lead, we formed a Mental Health Ministry Consortium for the Diocese of San Jose. Each parish took a different approach to Mental Health Ministry. Three managed this new ministry as staff-driven and event-based. Three chose to be volunteer-centric and began with Listening Sessions in each parish to assess needs and desires. One began with an idea from a volunteer social justice volunteer for an online support group for those experiencing COVID anxiety.

As project leader for 3GEN+ and the catalyst who encouraged the parishes to apply for the start-up funding from ACMHM, I assumed the lead as trainer for our consortium of eight parishes. I relied on the guidance of Margery Arnold, PhD, the coordinator of Mental Health Ministry in the Diocese of Orange, to help shape our eight-hour formation for Mental Health Ministers. Our goal was to form Mental Health ministers steeped in discipleship and spiritual accompaniment. In our training, we emphasized the skills of

Listening with the Ears of the Heart. Here is the overview of our formation for Mental Health Ministers:

HOPES—TRAINING OUTCOMES FOR PARISH-BASED MENTAL HEALTH MINISTERS

- Infuse with Catholic Understanding for Mental Health Ministry, using *Hope and Healing*, the pastoral letter of the Californian Catholic Conference of Bishops, as our key document
- Connect with other parish-based Mental Health Ministers, as co-ministers
- Increase confidence as parish-based Mental Health Ministers
- Develop competence as parish-based Mental Health Ministers

GOALS—PARISH-BASED MENTAL HEALTH MINISTRY

- Stop the stigma in speaking about mental illness
- Provide welcoming, safe, and sacred space from their faith leaders and other parishioners, for those seeking help
- Provide initial & ongoing formation for parish-based Mental Health Ministers to offer:
 - a. Prayerful companionship
 - b. Emotional and practical support
 - c. Links to mental health & other community resources

FIVE CORE PRACTICES FOR PARISH-BASED MENTAL HEALTH MINISTERS

1. Welcome the Stranger

2. Holy Listening
3. Companion on the Journey
4. Self-Care
5. Awareness of Self, the Other, and the Divine

The training included presentations, readings, role-playing, verbatims, and reflection. Ruth Auten, LMFT and a member of St. John Vianney, a local parish, helped facilitate the training. Ruth's affirmation of the role of faith, spirituality, and mental health gave confidence to the participants that the lack of professional credential did not hamper one from engaging as a Mental Health Minister. *We are not therapists or clinicians. We are ministers reaching out as the hands and feet and heart of Christ.* In 2021, more than 50 parishioners from one dozen parishes engaged in Mental Health Ministers formation. In addition to this core training, many of the Mental Health Ministers completed one or more of these trainings: Implementing Catholic Mental Health Ministry, University of San Diego, Mental Health 101, Santa Clara County NAMI FaithNet, Be Sensitive & Be Brave Suicide Prevention and Intervention, Santa Clara County Behavioral Health Services, Mental Health First Aid from various providers, including Deacon Ed Shoener from ACMHM.

Progress

We met our goals in implementing a Mental Health Ministry program at St. Francis of Assisi Parish. We also partnered with seven other parishes in the Diocese of San Jose, and in other neighboring dioceses, including Oakland, Orange, and the Archdiocese of San

Francisco, to deepen Mental Health Ministry in these three dioceses. Moreover, in response to the “bottom up,” parish-based implementation in the Diocese of San Jose, Bishop Oscar Cantu, bishop of the Diocese of San Jose, and Fr. Gerardo Menchaca, Vicar of Evangelization in the diocese, continue to offer full support to implementing Mental Health Ministry programs throughout the diocese. Recently, Fr. Menchaca commented that Mental Health Ministry programs in the Diocese of San Jose caught fire because the impetus came from the people, rather than being “imposed by the top.” To meet our goal of partnering with other Mental Health Ministers, Margery Arnold and I, both founding board members of the Association of Catholic Mental Health Ministers, lead networking calls every other month with other parish-based Mental Health Ministers throughout the country. These other ministers also received seed grants from the ACMHM.

Each month, we focus on a different topic, ranging from burnout to providing effective referrals to therapists. In December 2021, we showed the video from Pope Francis in which his worldwide prayer intention focused on those experiencing depression and burnout. As a result of showing the video during the networking call, all of the parishes in the Diocese of San Jose Mental Health Ministry Consortium screened the video as part of their December e-bulletins. As we continue to meet with the parish-based ministers from Hawaii to Houston, Margery and I observe a deeper sense of confidence in the ministers, as well as a mutual exchange of ideas and reciprocal support.

Factors That Facilitated and Hindered Our Progress

In my experience, the qualities that helped our Mental Health Ministry program to take root in the Diocese of San Jose are grounded in discipleship: deep listening, mutual support, encouragement, enthusiasm, perseverance, prayer, trust in God's goodness, and an acceptance in the spirit of Saint Oscar Romero that "we are Prophets of a future not our own." I note in particular:

- The willingness of Bishop Oscar Cantu, Pastor Fr. Matt Stanley, and Chancery staff members Fr. Dan Urcia and Fr. Gerardo Menchaca to affirm the ministry.
- The guidance and patience of Dr. Wendell Callahan and the Therapy team to take the first steps in parish-based Mental Health Ministry.
- The entrepreneurial confidence of "just begin!" and generous support of Deacon Ed Shoener, president and founder of the Association of Catholic Mental Health Ministers.
- The encouragement from colleague Dr. Margery Arnold in the Diocese of Orange. Rev. Cindy McCalmont in Santa Clara County NAMI FaithNet, and co-trainer Ruth Auten, LMFT.
- The enthusiasm of the parish staff and the participants in our four cohorts for Mental Health Ministers.
- The gratitude and humility of those with whom I stepped alongside to accompany.
- My husband, Rich Zahner, *the Accidental Volunteer*, embodies all of the qualities of discipleship.

In looking back, I see the biggest hindrance to our progress was (and is) fear. Fear of being in charge, fear of not being a licensed

mental health professional, fear of mastering new technology, fear of not enough time or volunteers, and fear of being “less than.” Whenever I sank to my chin in fear, I would return to our initial mantra: Get into the boat with Jesus. Fear converted to faith. With God’s grace, we would move forward with Mental Health Ministry. With God, nothing is impossible.

Resources: Time, Money, and Staff

My first response is that we simply took the time and money to do what was needed to complete the task at hand. At the CIMHM training in 2019, Deacon Ed Shoener estimated a paid person leading Mental Health Ministry could complete responsibilities in 10–15 hours per week. Looking at this past week, I volunteered this amount of time to Mental Health Ministry:

Volunteer Support	4.50 hrs
Spiritual Accompaniment	5.50 hrs
ACMHM	3.50 hrs.
Diocese of San Jose	1.50 hrs.
Administrative	<u>10.00 hrs.</u>
TOTAL	25 hours

Each of these activities advanced the implementation of the Mental Health Ministry program. Was this an ordinary week in time spent? While the activities may vary from week to week, in my experience, this week fit most weeks in the leading Mental Health Ministry program. If one eliminates work focused in supporting the two professional Mental Health Ministry organizations (CIMHM & ACMHM), the time in the parish Mental Health Ministry

program would decrease by 12.50 hours. Then the total weekly time invested would be 14.50 hours. While this figure mirrors Deacon Ed's 2019 estimate, for most volunteers, this is a steep time commitment.

The Impact of Our Ministry

In February 2019, we initiated 3GEN+ with a paper survey, offered in three languages at 11 different weekend liturgies. Our goal was to assess interest in Mental Health Awareness and Education and to determine which days parishioners favored for events. More than 900 parishioners responded. Here is the survey and the results (please note that responses do not add up to 100, as some questions were not answered):

ST. FRANCIS OF ASSISI PARISH

MENTAL HEALTH AWARENESS AND INTEREST SURVEY QUESTIONS

2/16/19-2/17/19

1. Would you like to increase your mental health awareness and receive information to get help for individuals with mental illness? RESULT: Yes—73%; No—25%
2. Do you believe Christians have a responsibility to care for and support those who are living with mental illness? RESULT: Yes—91%; No—5%
3. Would you or your family be interested in an informative session on mental illness? RESULT: Yes—65%; No—30%
4. If yes, what day and time of the week would be most convenient?

5. RESULT: Varied answers: Most popular: Sat—28%;
Sun—23%

In April 2019, NAMI Santa Clara County presented “In Our Own Voices” to adults and “Breaking the Silence” to teens and others. About 50 parishioners total participated. In the follow-up evaluations, attendees noted their increased mental health awareness. The also reflected on the honesty of the presenters and how that quality elicited empathy and a desire to support a Mental Health Ministry program. In July 2019, Deacon Ed Shoener facilitated Mental Health First Aid in the parish conference room. Thirty-nine parishioners and staff attended the eight-hour presentation. In reviewing the evaluations, Fr. Matt Stanley, pastor of St. Francis of Assisi Church, commented he had “never seen such glowing evaluations!” As part of designing our First Year of Mental Health Awareness and Education, Lisa Nakamura, director of Faith Formation, gave a survey to 63 parents on their greatest family stressors. The two top issues: communication with their children and the pressures of time on family life. Youth director Kevin Bernaga also surveyed 52 youth on their emotional and mental health concerns. Anxiety, depression, and stress led the list. Suicidal thoughts emerged as #4 on the list.

On November 23 and 24, 2019, we used the Mental Health Ministry Checklist from the University of San Diego to take the pulse of St. Francis of Assisi parishioners on Mental Health awareness. More than 800 parishioners from age 6 to 91 completed the survey. Here are the results:

PARTICIPANTS:

- Asian-Pacific Islanders: 57.6%
- White: 17.3%
- Hispanic: 7.2%
- African American 0.9%
- Women 58.5%

PARISHIONERS' RESPONSE TO MENTAL HEALTH MINISTRY, ST. FRANCIS OF ASSISI CHURCH, SAN JOSE, CA.:

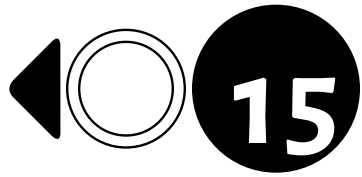
- My church has a mental health ministry.
Yes—46.5%; No—5.3%; Not Sure—47.2%
- My church is friendly to people with mental health problems.
Yes—68.9%; No—12%; Not Sure—19.1%
- Mental Health Information is available.
Yes—45.5%; No—3.5%; Not Sure—49.2%
- Prayer cards are available.
Yes—25.0%; No—5.2%; Not Sure—67.9%
- My church provides referrals to mental health professionals.
Yes—32.0%; No—4.9%; Not Sure—61.3%
- I attended mental health events.
Yes—10.5%; No—70.6%; Not Sure—17.1%
- My church offers prayer service for mental health.
Yes—46.6%; No—6.1%; Not Sure—44.6%

- I would talk to a priest about mental health problems.
Yes—35.7%; No—30.9%; Not Sure—30.4%
- I know mental health ministers at my church.
Yes —10.3%; No—57.7%; Not Sure—29.8%
- I would talk to a mental health minister about mental health problems.
Yes—37%; No—29.3%; Not Sure—30.7%

In 2020, we administered no surveys or evaluations. In 2021, our Mental Health Parish Consortium in the Diocese of San Jose screened *Angst*, *Like*, and *Upstanders*, three films on Youth Mental Health. We collaborated with the ACMHM-funded parishes from the Diocese of Orange in screening the films via Zoom. Each screening was followed by an interactive panel of mental health professionals and clergy experienced in emotional and spiritual well-being. The panelists spoke from their professional and lived experiences. About 1,400 registrants signed up for the IndieFlix-produced films. After each screening, the chat boxes filled with questions about anxiety and teens, the impact of social media, and the effects of cyber-bullying. *Upstanders* includes testimony from a family whose son died by suicide as a result of cyberbullying. Panelist Fr. Matt Stanley, pastor of St. Francis of Assisi Parish, answered a question about the Church's stance on death by suicide. Fr. Matt offered compassion and pastoral care swaddled in God's love for all. Moved by Fr. Matt and the other panelists speaking of Divine Care, producer Scila Andreen exclaimed, "I feel like I have been dipped in a vat of love. Thank you!" What a powerful image of ministry!

LESSONS LEARNED

1. Be not afraid. Jump into the boat with Jesus!
2. Collaborate with local organizations, especially NAMI and County Behavioral Health Agency.
3. Form a team. Divide up the work. Know that everyone brings gifts to the Mental Health Ministry.
4. Take time for listening sessions to hear parishioner concerns.
5. Accept that the mental health ministry may face resistance. Back to #1.



CHAPTER 15

MENTAL HEALTH MINISTRY IN THE ARCHDIOCESE OF SAN FRANCISCO

RICHARD COLLYER & ED HOPFNER

The Archdiocese of San Francisco is a large, urban/suburban diocese with a widely diverse population (ethnic, cultural, and economical). There has been a lack of general support for those families and individuals suffering from mental illness. The archdiocese had no organizing structure to provide these resources to parishes, which are the first place our parishioners go for help. The need is growing, but our resources have been shrinking.

Our Proposal

We intended to develop and implement a completely new ministry. The program would provide education, training, and other resources to parishes so that they could respond to the needs of Catholics and others whom they serve. This ministry would be our response to the high percentage of Bay Area individuals and families with mental health issues, and our archbishop's particular

commitment to the underserved “least” of our faithful. It was also a response to the call of the California Catholics bishops, as outlined in their document *Hope and Healing*, that “ministering to those who suffer from mental illness is an essential part of the pastoral care of the Church.”

To the extent possible, we proposed to follow the model of the San Diego Mental Health Ministry Network, since it has already proven highly successful at the diocesan level. They had developed a clear structure for training and implementation that could easily be adapted to our archdiocese, and is easily accessible for ongoing consultation.

Coordinating Related Ministries

There are currently a variety of ad hoc ministries provided at the archdiocesan level, related to mental health, which are either implemented in various parishes or by the archdiocese itself. These programs include: 1) prison ministry; 2) support for families of incarcerated; 3) restorative justice and victim’s assistance—for those victims of violent crime; 4) re-entry programs for formerly incarcerated; 5) victim’s assistance—for those abused by clergy or religious of the archdiocese; 6) grief ministry; 7) Project Rachel (post-abortion healing); 8) divorced Catholic’s ministry; and 9) periodic seminars on Alzheimer’s. The archdiocese provides a comprehensive list of local service providers on their website. These efforts to provide mental health resources serve a variety of our parishioners, yet there were still many gaps, and the need for resources was growing.

Our new ministry would “fill in the gaps” offered by these various programs, so we could provide a more holistic response to our parishioners’ needs, and more directly target mental health issues at the parish level. We would train parish teams to provide educational resources and pastoral accompaniment, and to assist pastors in finding the best local resources for the people, including non-parishioners, who come to that parish seeking help. While the teams would be a resource for all who come for assistance, they would be of particular help to underserved populations in our archdiocese: minority ethnic and cultural groups, undocumented populations, those displaced by shifts in the economy, those recently released from incarceration, middle-class families under stress from living in the most expensive urban area in the country, and other with diagnosed mental illnesses. Our current Mental Health Ministry Network is made up of 12 parish teams.

Formation & Training

In early 2019, a Mental Health Ministry initiative was begun by the University of San Diego’s Catholic Institute for Mental Health Ministry in conjunction with the Diocese of San Diego. San Diego, at that time, was leading the country with a model of building mental health ministry teams at the parish level. Five dioceses, including the Archdiocese of San Francisco, received grants to help jump-start the creation of ministries in their own respective locations. Four of us representing the Archdiocese of San Francisco and the Diocese of Oakland spent three days getting briefed and trained on how a ministry like this could be implemented locally. The model that the

Diocese of San Diego used has been leveraged and tailored to meet our needs in our archdiocese.

We started our journey by building awareness and commitment with some of the pastors throughout the archdiocese. Interested pastors allowed us to have parish recruitment workshops at their respective parishes. Following this lay minister recruitment, training for the parish teams was to begin. However, in 2020, COVID and the lockdowns forced us to reassess and shift to online training for the initial parish teams.

Each parish team received customized training (five parts) over the course of a few weeks, approximately 10 hours in total. Those five parts included 1) NAMI Mental Health 101, 2) Helping and Understanding Alzheimer—Dementia, 3) Communications with Those Suffering from Mental Health Challenges, 4) Parish Ministry Deep-Dive Implementation, and 5) Q&A with Our Lady of Mt. Carmel Parish ministry lead. This began the formation and development of a broad network of Mental Health Ministry Teams spanning all three counties in the archdiocese.

We currently have more than a dozen parishes that have been fully trained and are in various stages of implementation. These Mental Health Ministry Teams meet every other month to listen and learn from each other. The keys to successfully building parish teams have been the support from the clergy and finding strong lay leadership within the parish. In addition to the training above, in August 2021 a Mental Health First Aid training course was delivered to 30 parish team members representing 10 parishes in the Archdiocese.

Progress

In the spring of 2018, at an annual gathering of California diocesan leaders, we heard a presentation from Kent Peters of the highly successful Mental Health Ministry program he had developed in the Diocese of San Diego. Following the conference, we wanted to initiate a similar program in our Archdiocese of San Francisco. We were delighted when told that Wendell Callahan at the University of San Diego had received funds for a grant to be offered to up to five recipients as seed money to start their own programs. We applied for a grant and were even more delighted to be selected as one of the awardees.

In Fall 2018, we outlined a roadmap to develop a local program, and in February 2019 hired Dick Collyer to spearhead the initiative. Though our grant was for three years, we thought he could get the program going in two years, and then work on a “contract” basis as needed once it was established. During the first year, he organized publicity in the archdiocese for the program, invited our clergy to informational luncheons, and then followed up with individual parish visits to recruit potential Mental Health Ministry Team members. We were ready to begin training parish teams when COVID-19 and our California lockdowns hit. Fortunately, Dick was able to pivot and develop virtual training over Zoom, as many other groups have done.

While our team was in San Diego in February 2019 to get oriented to the grant and the Catholic Institute of Mental Health Ministry (CIMHM), we were curious about the actual training that would be done for parish teams—what was the content? Since that question was never fully answered, we designed our own training

program. We feel we now have a well-developed template and robust training program that could be a model adopted by other dioceses seeking to create a mental health ministry network.

Steps to Implementation

STEP 1. FILL “NEW” POSITION IN THE ARCHDIOCESE: THIS PERSON WILL HAVE THE RESPONSIBILITY FOR ORGANIZING AND IMPLEMENTING THE MENTAL HEALTH MINISTRY PROGRAM IN PARTICIPATING PARISHES.

A search for a director began in December 2018. Dick Collyer was identified to lead the project in late January 2019 and was hired as a part-time, temporary employee by the Archdiocese of San Francisco to head our Mental Health Ministry Network project in February 2019. The position reports to the director of Marriage and Family Life (M&FL). In late February, the project manager and director of M&FL attended training in San Diego to kick off the initiative.

STEP 2. BUILD CLERGY AWARENESS AND SUPPORT FOR MENTAL HEALTH MINISTRY BY PLANNING CRITICAL EVENTS FOR KEY STAKEHOLDERS IN THE ARCHDIOCESE:

- **Deacons:** A key presentation was made at an archdiocesan deacon meeting in early May 2019 to build awareness and support for the direction and goals of implementing an Archdiocese Mental Health Ministry Network. More than 35 deacons and deaconate candidates attended, along with several of their spouses. The survey responses showed

almost unanimous agreement that attendees wanted to know more about mental health disorders. Two-thirds of those surveyed indicated that attendees wanted more mental health training. Half of the deacons and deaconate candidates saw their parish wanting/supporting a mental health ministry.

- **Presbyteral Council:** A presentation was made to the Archdiocese Presbyteral Council on May 9, 2019, to introduce and provide an update of the plans to implement an Archdiocese Mental Health Ministry Network. In addition, results from the deacon meeting survey were shared and next steps were made for a clergy luncheon. San Francisco Archbishop Salvatore Cordileone and the Presbyteral Council were very supportive.
- **Priests:** In late August 2019, a Mental Health Ministry Clergy Luncheon was held at Mater Dolorosa Parish, with 33 priests and 9 deacons attending. Clergy had the opportunity to gain more awareness on mental health issues, better understand the impact of implementing a mental health ministry parish team, and be invited (those in attendance) to have the opportunity for their parishes to participate in the first phase of implementation. A questionnaire resulted in 11 parishes that voted “yes” to pursue a ministry team and 10 voted “maybe,” requesting more information and additional discernment before making a decision. Based on the voting and additional interest, we expected to have at least 20 parishes interested in ministry teams during this first phase. Overall, feedback from attendees was positive. This luncheon was a major milestone in our plans.

STEP 3. RECRUITMENT

Parish recruitment workshops were scheduled for those parishes where the pastor expressed interest in having a Mental Health Ministry Team. Three parish recruitment workshops were held in California in late 2019, at Our Lady of Angels Parish in Burlingame, St. Hilary Parish in Tiburon, and St. Anne's Parish in San Francisco. All three counties in the archdiocese were included. The statistics on mental illness were an eye-opener for many who attended. They left with enough information to discern whether they want to apply to be on their parish Mental Health Ministry Team (the pastor would have final say on who would be on the team). The parish recruitment workshops were continued in 2020, with a total of 12 parishes attending. The recruitment workshops were done in-person during the first two months of 2020. We had one more parish—St. Raymond—join at the end of 2020, when the workshop was online due to COVID. This brought the total number of parishes interested in forming a parish mental health ministry team to 15.

STEP 4. DEVELOP STANDARDS AND GUIDELINES

We developed and rolled out standards and guidelines for the Archdiocese Mental Health Ministry Network to use in their parish ministry teams. This included:

- Tri-fold communication brochure: Developed a Mental Health Ministry Network brochure that explains the three key elements of the Mental Health Ministry, has background information on Mental Illness, and a message of support from Archbishop Cordileone.

- Scope of the Volunteer (one-page document): Leveraged Our Lady of Mt. Carmel Parish in the Diocese of San Diego to help explain the scope of the parish volunteer. A copy of this document is given to the person seeking assistance from the Mental Health Ministry Team.
- CMHM Guidelines for Implementation: Purchased 85 copies of *Guidelines for Implementation* and sent to parish teams that have been trained. Parish teams use this as a reference guide in developing and implementing a ministry team.
- Resource List: Develop an archdiocesan list of resources, specifically therapists/counselors to share across parish teams. We have a shared list of resources that cross the three counties in the archdiocese.
- Monthly parish team leader meeting: Started monthly parish team leaders meetings to share best practices/information and maintain standards across parish teams.

STEP 5. TRAINING

We planned and developed training for parish ministry team leaders and members.

Planning was completed in late February 2020. The training was scheduled for March 14, then initially postponed to May 16 due to COVID. The training in May was again postponed due to COVID, which caused a total reassessment of how to train the parish teams.

The entire parish training program needed to be redesigned from in-person to virtual.

- Separate 90-minute virtual training sessions were developed that leveraged the Zoom platform. This included taking the three key parts from the original in-person training: Mental Health 101, Helping and Understanding Alzheimer/Dementia, and Communication with Those Suffering from Mental Health Challenges. The three primary trainers agreed to deliver their material online.
- The training was piloted with St. Matthew's Parish in late May. Adjustments to the virtual training were made for future parishes, and additional required parts beyond the original three were added (there was a need for a deeper dive into the implementation at the parish level). A separate training session was also introduced that follows the Catholic Mental Health Ministry *Guidelines for Implementation*.
- In addition, a Q&A session with the Our Lady of Carmel Team leader from the Diocese of San Diego was added. We now have five separate sessions that are recorded and can be used for the next set of parish teams. We have another 7 to 10 parishes that might be interested in building a ministry team at this point.

Implementation Factors

The implementation of the Mental Health Ministry program for the Archdiocese of San Francisco has progressed at a steady pace. Initially, a lot of effort was focused on helping pastors and parishes to understand the goal of getting as many parishes committed to having Mental Health Ministry Teams. To get a parish team started, we needed commitment from the pastor of the parish that he wanted and would support a team. This included numerous one-on-one

discussions and larger events to build awareness of and commitment to the initiative.

Once we had a reasonable number of pastors willing to take the risk, the implementation of the Mental Health Ministry program for the Archdiocese of San Francisco was disrupted due to COVID-19, causing delays in the rollout. The Bay Area had highly restricted limitations on meeting/gathering of groups during a critical point in the rollout of training to parish teams. Significant additional work and creativity were required to preserve the momentum. All the training was moved to virtual online sessions and expanded to other areas as needed. Progress was delayed and slowed down, but never stopped. We added additional parishes that were not in our original plans, as others have deferred to a later implementation. The impact of COVID was significant, but there has been a silver lining with the increased awareness of mental health issues and accompanying stigma. Everyone has been impacted by the pandemic lockdown to a certain degree, especially with coping with depression. However, the stigma around mental health still exists and has been a difficult area to overcome. The key has been to continue ongoing education with the parish teams, clergy, and parishioners.

Resources

The main resource that was allocated to the initiative has been the part-time project manager for the last three years to oversee the design and implementation of all the components of establishing a Mental Health Ministry Team. We implemented a top-down approach methodology from the archdiocese out to the parish level—this included education/awareness sessions, parish

recruitment workshops, developing all training material, scheduling, and delivering all the steps to enable a parish team to progress.

Each parish has a volunteer team that includes at least one leader (in some case, two co-leaders) to shepherd the remaining Team Members in their respective roles. A recommended model has been used and tailored to each of the parish requirements. The Teams typically have a spiritual accompaniment role/contact person, resource person, and education/awareness person. However, these roles can be combined and additional roles added, for example a prayer leader role. Again, the roles and design of the parish teams are left to the leaders to determine.

Evidence of Impact

The primary keys to successfully building parish teams have been the support from the clergy and strong lay leadership within the parish. Following are quotes from two of our parish team leaders.

TEAM LEADER FOR ST. MATTHEW'S IN SAN MATEO:

Our Mental Health Ministry has had a positive impact on our parish community. We have had opportunities to walk with families and individuals who are going through difficult times. Our team has corresponded mostly through Zoom, listening to people's stories and providing them with resources that can truly help them. Although we are not health care professionals, we can connect people with those who are. Our role is to offer support, encouragement, compassion, and Christ's presence. I have been exceedingly

impressed with our team's ability to do all of this for each person who has approached us.

TEAM LEADER FOR ALL SOULS IN SOUTH SAN FRANCISCO:

Since the inception in January 2021 of the Mental Health Ministry at All Souls Parish in South San Francisco, we have managed to heighten awareness of mental health challenges through the bulletin, a dedicated email address and cell phone number, word-of-mouth, engagement with other parish ministry leaders, monthly educational sessions, and fundraising to develop our own working budget. While we are gratified with measurable traction, the stigma around mental health remains the single most remarkable barrier.

As noted, we were successful in establishing teams at several parishes prior to the arrival of COVID. Great momentum had been established, and all indications were that this critical ministry would be well received. As a result, it was tremendously frustrating when COVID hit, restrictions were implemented, and we were not able to convene in-person to formally introduce the ministry, recruit parish teams, and train volunteers.

In addition, many parishes fully (and somewhat understandably) retracted, decreasing most—if not all—of their activities. That said, we continued moving forward as much as possible due to our belief in the vital nature of this ministry. The need to address it became increasingly urgent as the pandemic continued.

As the restrictions gradually lifted in the Archdiocese of San Francisco, we were able to host our first Mental Health conference—*Hope & Healing*. The conference opened with a strong message from our vicar general on the importance of *Hope & Healing*, referencing the California bishop's pastoral letter. We featured speakers who touched on several aspects of mental illness, including two keynotes on Mental Health 101 and Coping Skills for Family Members. In addition, we had six breakout sessions focused on a variety of themes:

- Psychological Hardiness and the Spiritual Life
- Suicide Prevention
- Depression, especially related to COVID
- Spiritual Response to an Unhealthy Culture
- Addiction/Substance Abuse
- Mental Health Challenges in Children & Youth

Overall, the attendance included more than 100 people from around the Bay Area, representing 40 parishes and several non-Catholic organizations. Six informational exhibitors provided key resource material, and we had a separate information table for other mental health needs. Feedback from the conference attendees was collected from 60 percent of the attendees with an exit evaluation. Fortunately, 100 percent of all attendees completing the exit survey stated they would recommend this conference to others and wish to do attend the conference again.

In addition to the surveys we collected after the conference, we collected feedback about impact from other sources. Discussions with community members, even those who have not been directly affected by mental illness, elicited reactions similar to what is noted

previously. Several people with whom we and other members of the archdiocese have spoken noted that mental illness wreaks havoc on families in countless and unforeseen ways. Many have expressed the belief that this has become even more pronounced as the result of COVID, and thus the need for a parish-based program, where there is an inherent level of trust and comfort with the people with whom they are speaking.

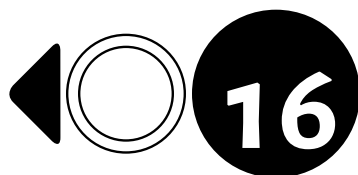
OUR OWN PERSONAL REFLECTION HAS ALSO BEEN A SOURCE WE HAVE DRAWN ON TO UNDERSTAND THE IMPACT OF THE MINISTRY. REFLECTING ON THE MANY CONVERSATIONS THAT HAVE TAKEN PLACE, IT REMAINS CLEAR THAT THIS MINISTRY PLAYS A CRITICAL ROLE IN THE NEEDS OF PARISHIONERS AND THEIR FAMILIES. EVERYONE THAT WE HAVE SPOKEN TO OVER THE COURSE OF THE LAST THREE YEARS HAS SEEN THE NEED FOR THE CHURCH TO PLAY A SIGNIFICANT ROLE IN THE RECOVERY OF THOSE SUFFERING FROM MENTAL HEALTH CHALLENGES. WE HOPE THIS WILL CONTINUE.

LESSONS LEARNED

In this brief section, we share a few of *takeaways* from our experiences to pass along to readers planning or implementing a Mental Health Ministry program. We include both things we did well, along with things we might do differently:

1. Focus your time on those parishes/pastors who really want this ministry. Identify them early and move quickly through the selection process. If they cannot see the benefit or do not have the time to invest in this ministry, move on. Too much time can be wasted in spending time with a parish/pastor that is not willing to participate.

2. Leverage external expertise. There are many people who can help, in the parish as well as the secular community. Find them and use them to help to develop and implement the plan. Find key leaders in the parish teams to help with the rollout (ask the pastor for help). Leverage their expertise and use them as a sounding board for feedback, so you can make adjustments to your plans.
3. Continue to educate and build awareness in your parish teams on the ever-moving field of mental health. Try to drive out the stigma as best you can. This will help the ministry thrive going forward. Be compassionate for those seeking help.
4. You do not have to have all the answers! There is no timetable on this journey. Listening to someone who is struggling is sometimes all we need to do.
5. Last but the most important—PRAYER. Do not forget the importance of ongoing prayer over the team and all the people they will encounter on this journey. We cannot do it alone!



CHAPTER 16

MENTAL HEALTH MINISTRY IN THE ROMAN CATHOLIC DIOCESE OF ORANGE, CA

MARGERY ARNOLD & LINDA JI

Why We Implemented a Mental Health Ministry

Among the many areas of ministry overseen by the Office for Family Life in the Diocese of Orange, mental health ministry has been a priority in recent years because it is a particular area of interest and leadership for Bishop Kevin Vann. Bishop Vann partnered with Rick Warren of Saddleback Church in 2014 to host the ecumenical Gathering on Mental Health, which drew thousands of participants in person and via broadcast around the country. As part of this partnership, both the Roman Catholic Diocese of Orange and Saddleback Church made a public commitment to journey alongside families suffering with mental illness. Bishop Vann also played a key role in the California Catholic Conference of Bishops' 2018 pastoral letter on ministry to those with mental illness, *Hope and Healing*. As a result of Bishop Vann's leadership, several parishes started

Mental Health Ministry programs prior to the diocese receiving this grant.

As Bishop Vann wrote in an introduction letter to our grant proposal, these grant funds provided the resources and staff needed to grow and expand and to bring further support so that existing and new ministries could flourish in the Diocese of Orange:

This is a great providential moment in our Diocese to call and bring together the early ministries that began after our Gathering on Mental Health and the Church in 2014, to renew our commitment in light of “Hope and Healing” and to engage the faithful in a pointed way to recognize the suffering in our midst, to cast out fear and respond in love. Like the man born blind in John’s Gospel, our brothers and sisters with mental illness offer us a chance to witness “the works of God being made visible through them.” For this, we must be present to these brothers and sisters. I hope through the efforts of our Office of Pastoral Care and the fostering of parish mental health ministries as outlined in this proposal, all in our community can be present to partake in the miracles of mercy and compassion through which Christ reveals the wholeness and restoration intended for each and every one of us.

Setting & Population Served

The Roman Catholic Diocese of Orange serves 1.3 million Catholics in Orange County at 59 parishes and three centers. Orange County is located in Southern California between Los

Angeles and San Diego Counties. Masses in this diocese are regularly celebrated in English, Spanish, Vietnamese, and Korean, and often in Tagalog, Polish, and Chinese. We now have Mental Health Ministry Teams in 14 parishes.

Composition of Ministry Teams

There are two to five people in leadership at each parish. Most are Catholics who have been touched by mental illness—either by being diagnosed or by having a family member with a mental illness (or both). Sometimes, there are mental health professionals on the leadership team, but most are not professionals. In addition to the leaders at each ministry, there are others who are involved in other capacities (prayer leaders, publicity, support group leaders, hospitality, etc.). We are a diverse group of networked disciples who care about reaching out to those on the margins. We hold dear the Catholic values of solidarity and subsidiarity. Each Mental Health Ministry program forms *from the ground up* to meet the needs of a particular parish or community.

The parish teams are supported by a diocesan Mental Health Ministry coordinator, who provides guidance, training, and resources and connections to community agencies for parishes. Most importantly, the diocesan coordinator keeps the parish teams rooted in the ministry's mission and provides spaces for spiritual reflection and mutual encouragement.

Formation & Training

We have used many methods for assembling teams. We have found it helpful to have an event such as a speaker to draw people

interested in the topics of mental health and faith. At those events, we declare an intention to start a Mental Health Ministry in the parish and invite anyone interested to join the leadership team. We prefer to have two to three persons from a parish to serve as a leadership team. After an initial meeting with the pastor and the interested parties, a plan is formed to train parishioners who lead the ministry. The leadership teams go to a six-hour training that includes topics outlined next.

After that six-hour training, the leaders begin organizing ministry events and finding ways to best serve their community. Anyone who joins the ministry does not need to go to the leader training, but we do ask that they complete Introduction to Mental Health Ministry (a one-hour training that can be read online or given by leaders to parishioners in person) as part of their onboarding process and then complete Mental Health First Aid within the first year. There are some parishes and ministries who would like more training, and sometimes the MHM coordinator can provide that training. Other times, she can direct the team to available online (e.g., St Luke's Institute—SLI Connect, University of San Diego Catholic Institute of Mental Health Ministry or the diocese's own portal Emmaus Institute) or community-based trainings through our local public health agency or nonprofit agencies.

TOPICS: INTRODUCTION TO MENTAL HEALTH MINISTRY (1 HOUR)

- What is mental health?
- How common are mental illnesses?
- How common are they in our parishes?
- What keeps us from helping one another with mental illness?

- What can we do to break down stigma?
- How is stigma different in different communities?
- Why should the Catholic Church be involved?
- What is Mental Health Ministry?
- What are the goals of Mental Health Ministry?
- What does a Mental Health Ministry program do in a parish? How do they do it?
- How do we know what is the best way to meet our parish's needs with a Mental Health Ministry program?
- What is a parish Mental Health Ministry Team? Who is involved?
- How will I be involved in the ministry?
- How do I help someone who is struggling with a mental health challenge?
- How do I pray with them?
- How do I connect someone to mental health care and to our ministry?
- What if there is an emergency?
- Who should we connect to our mental health ministry? Parish? Diocese? National? Outreach?
- What resources are available in the community to help our ministry?

Remember: ministry means going to people, where they are, getting to know them, and helping them to come closer to God. How can you be a door or a bridge between others and God?

TOPICS: PARISH MENTAL HEALTH MINISTRY LEADER TRAINING (6 HOURS)

- Topics from the Intro course, covered in more detail

- How to implement a mental health ministry: accompaniment, inclusion, & organizational tools
- Who should I involve and what are their roles?
- How do we onboard and train Mental Health Ministry members?

Progress

We have launched parish-based Mental Health Ministry Leaders and Teams in nearly a quarter of our parishes (14 out of 59) and trained many individuals among the faithful. These trained Mental Health Ministers and individuals know how to provide spiritual support to those with a mental illness. We have three goals for our ministry: (1) to lower or eliminate stigma in our parishes, so that we can better welcome and love one another; (2) to increase the likelihood that parishioners will reach in when they see someone who might need help; and (3) to increase the likelihood that there will be a group of parishioners who feel equipped to provide prayerful companionship, emotional and practical support, and links to mental health and other community resources.

Each ministry team works toward these goals with a variety of activities that meet the needs of the parishioners and also meet the parishioners where they are with regard to stigma about mental illness. Mental illness is conceptualized in a variety of ways and is often influenced by culture. Thus, we think it is important that each team be free to choose their own approach to Mental Health Ministry based on what they know about their community and their parish. What does that look like? It is different in each community. It can look like people gathered to pray the rosary or as a support group for family members. In one parish, it is a monthly gathering

with hospitality, a speaker, and discussion groups. During COVID isolation, we had an online faith recovery group using a curriculum from Grace Alliance and that has continued in person at a centralized parish.

Some parishes are using the *Sanctuary Course for Catholics* to raise awareness and to educate Catholics on how our faith can be an asset to mental health recovery. Several parishes have presented movies on current topics in mental health (social media, youth anxiety, bullying), followed by a question-and-answer session from a panel of faith leaders. In some parishes, there are therapists and priests each talking about a mental health issue from their perspective and then taking questions and answers from the group. In other parishes, lay ministers bring in speakers and resources to their community in the languages they prefer to speak. In another parish, it is simply parishioners who will sit and pray with individuals about health concerns after Mass.

Implementation Drivers & Blockers

One driver has been a focus on the ministers as a community and building that community. We are inspired by 1 Corinthians 12, which tells us about spiritual gifts and about being a member of the Body of Christ. We know that we cannot do this ministry alone, but when we work together, the work is more sustainable and more joyful. We do not always know what will happen, but we trust that the Holy Spirit will provide us with the people, gifts, and resources needed.

We try to stay connected by having monthly meetings of all parish Mental Health Ministry Team Leaders, during which we pray

for guidance and for one another, celebrate successes and work together on difficulties, and learn about community and faith resources. We also invite each other to events at our parishes and share our events on our chapter website provided through the Association of Catholic Mental Health Ministers (Catholicmhm.org/orange). As one minister said after attending a retreat put on by another parish:

We [members from St. Irenaeus Mental Health Ministry] attended the rosary-making retreat hosted by Elena and Cherie [leaders at St. Martin de Porres Parish]. It was beautiful. Elena made a printed booklet including the Litany to St. Dymphna for their rosary reciting. I voluntold them to share [with other parishes in the diocese] and they agreed. ... In reflection, MHM through your position has been a collaborative effort among all the parishes involved. This has prompted us to work together in ways I have not seen before.

Another driver has been our guiding values of subsidiarity, solidarity, the dignity of human life, and having a preferential option for the poor. All of these Catholic values are similar to a secular model in public health: the Community Capacity-Building Model. Both of these approaches to social issues tell us that the people most effected by a health problem can be the drivers of the largest amount of social change for that problem. Their concern for the issue and for one another helps them to learn the leadership skills and gain the knowledge needed to solve the problem at hand. While they work together to solve the problem, they increase the capacity of their

community to address the problem at hand, as well as other community concerns.

One implementation blocker has been stigma and fear. We counteract these by sharing how mental illness has touched our families or ourselves and how our faith was strengthened through those challenges. We also try to educate ourselves about stigma and then nonjudgmentally notice it in a public way when it happens among us (e.g., “Did you hear that? I did. I just said _____. Maybe I should have said _____. I’m working on reducing stigma in my language. Sometimes I don’t even notice it in myself. Please help me to do this by kindly noticing when I use language that indicates stigma against the mentally ill.” Or, “I feel sad when I hear you use the word ‘crazy’ to describe yourself. I see you as joyful, caring, and creative. Please don’t call yourself crazy.” After we notice the stigma, we try to correct its effects. Finally, we show the ways in which people’s experiences with mental illness can give insights and skills that are helpful to the community; we value each human life.

Another blocker has been communicating our message to the full Catholic public of the diocese amid so many other messages. We wish that we had more resources in the area of communication so that we could give time to creating more media about our ministry and our events. We have allocated time when media groups (Catholic newspapers or radio) were interested, but we likely would have been more successful if we had stronger communication skills for a modern media environment.

Finally, the COVID pandemic was both a blocker and a driver. So many more people are prioritizing their mental health, thanks to all the difficulties associated with isolating and the interruption of life as usual. However, most of our parish ministries were just

launching when the pandemic hit, so it was difficult to establish routines to keep the ministry going. With staff time dedicated at the diocesan level, the ministers were able to stay connected to each other and brainstorm together how to meet challenges.

Resources

The main resource we have had in our diocese is time—dedicated staff time (15 hours/week) combined with time offered by volunteer lay ministers. The way we have used time over the grant has differed according to the phase of implementation we were in and the factors influenced by the COVID pandemic.

PHASE 1: PRAYER, DISCUSSION, AND PLANNING (JAN–AUGUST 2019)

The Diocese of Orange devoted one staff person, a Mental Health Ministry coordinator, or 15 hours per week. She reported to the director of the Office for Family Life, who oversaw the program, and was supported with administrative work by the administrative coordinator, who supported two ministry offices in the diocese. The director and the Mental Health Ministry coordinator met weekly to pray, trouble-shoot, and discuss plans. Our plan was to grow in a grass-roots fashion, from the bottom up. In the beginning, this meant spending a lot of time going to meet Catholics who had been identified as already interested in mental health advocacy (about 50 people, of whom 10 to 15 were actively providing NAMI classes or other educational and resource events in three parishes) and listening to them regarding what they thought was needed. In addition, we already had a diocesan Mental Health Advisory Board that met monthly (comprised of diocesan staff, mental health

providers, deacon couples, family caregivers, and those with lived experience).

An important training during this time was the Mental Health Ministry training provided by the Catholic Institute of Mental Health Ministry (CIMHM) in February 2019, which was attended by three staff and two volunteers from our diocese. We continued meeting with people whom we knew cared about the issue of mental illness and continued building a network. In the fourth and fifth months, we were starting to hold events (informational talks, discussion, resource tables, and hospitality) at three other parishes to draw people who were interested and encourage them to form a parish ministry. Six months in, we had our first Mental Health Literacy trainings. By that point, we had a spreadsheet of about 125 people on our network list. We then spent most of the seventh and eighth months planning a training to form parish Mental Health Ministry Team Leaders. We asked parishes to send teams of three to five people to the training. During these initial nine months while the coordinator was building this network, the director of the Office for Family Life was building a network of therapists to whom priests, deacons, and Mental Health Ministers could refer parishioners in need of health care.

In addition, the director continued to update yearly a resource list of low-cost mental health resources as well as the therapist list (twice yearly). She also sent a package of resources, homily starters, and event ideas to pastors each year in advance of Mental Health Awareness Month. During this time, the coordinator also met online for an hour every other week with three other parishes or dioceses that received funding from CIMHM.

PHASE 2: TRAINING LEADERS AND SUPPORTING THEM TO BUILD THEIR MINISTRIES (SEPTEMBER 2019–MARCH 2020)

During the fall semester of 2019, we had a public health intern (volunteer) who assisted the coordinator to hold our initial leader training and then hold monthly follow-up meetings (via Zoom) through which we guided our recent trainees to survey their parishes and begin forming ministries that addressed the needs of the parish. The intern assisted in setting up a Google drive through which we could share resources (publicity, sign-up lists, training materials, surveys, onboarding of volunteers). The habit of leaders meeting monthly in a virtual format became very important to our continued success once the pandemic hit in March 2020. By that time, we already had the habit of meeting virtually to celebrate wins and problem-solve together and to pray with one another.

We were able to continue those monthly meetings when almost nothing else was happening as usual in Spring 2020. After the intern left, one of the attendees of the leader training whose parish was not yet ready for a Mental Health Ministry program devoted her volunteer work to taking minutes of meetings and assisting with onboarding new members of the ministry (through the diocesan website) and continuing to build our database of persons involved in Mental Health Ministry. This allowed the coordinator to start a monthly newsletter (with the administrative help of the coordinator for the Office for Family Life) to the persons we had in our database.

PHASE 3: PANDEMIC AND RESPONSE: VIRTUAL CONNECTIONS AND MINISTERING TO MINISTERS WITH CONTINUING PRAYERS (MARCH 2020–MAY 2021)

When the pandemic first hit, we paused our ministry, but we continued meeting virtually and kept our network together. At that time, the Office for Family Life lost its administrative coordinator due to diocesan wide layoffs. As a result, we were not able to publish a newsletter as often, as some administrative support is critical to maintaining that communication. Some things that we were able to continue doing were: training leaders of Mental Health Ministries, offering a virtual spiritual support group at the diocesan level, showing movies followed by Q & A with a panel of Catholic spiritual and mental health leaders, sharing the Sanctuary Course for Catholics and holding discussion groups, and providing Mental Health First Aid courses virtually. Early in the pandemic, we were able to share COVID resources via our website, including a phone conversation guide for parishes to use in reaching out to their homebound parishioners during the lockdown. We also made copies of our Mental Health Resource List and brought them to Catholic Charities to have the resource list put into food bags to be distributed by volunteers. By late summer, some of the NAMI support groups and courses started up again in a virtual format.

One of the ministries that had been going strong and was the first to hold parish-wide ministry meetings folded as the leaders were skeptical about the value of virtual ministry. Other parishes continued to meet outside to pray together or online. One major consequence of the pandemic was that the Mental Health Ministry coordinator slowed down on starting new parish ministries and

began providing more direct programming from a diocesan level instead. This was not the original intent, but it was one way to keep the ministry going until volunteer ministers felt comfortable and able to meet in-person again at parishes. Nevertheless, ministries at six new parishes were formed during this time, five of which continue today. She also spent much more time refining the Parish Mental Health Ministry Team Leader training. Also, with the help of two volunteers we were able to get both of our trainings translated into Spanish. Getting these two trainings completed required a lot of reflection and discussion, in addition to time spent creating the slides.

PHASE 4: JUNE 2021-DECEMBER 2021: REFLECTION, COLLABORATION, & PLANNING

During this time, the coordinator continued to offer Parish Mental Health Ministry Team Leader training, and volunteers and the county Health Care Agency provided Mental Health First Aid training. In addition, staff time was spent reflecting on what had been accomplished during the three-year time period of the grant project and what we want to make sure is solidified and established to move forward after the grant period ends. Further, the Office for Family Life spent time planning for how to keep this ministry alive, aligned with the strategic plan of the Diocese of Orange, and responsive to the needs of the parishes. We are pursuing a grant that could help keep the ministry growing into the next few years. We also recently received a small grant to provide funding for large events to help grow the ministry and make it better known.

throughout the diocese by helping lower stigma among ancillary ministries and departments in the diocese.

Over time, our understanding of mental health ministry grew from being one of providing information and resources to one of accompaniment. There are many sources of information and referral in the secular world, but only the Church provides this kind of pastoral ministry. We still provide information and resources, but we try to make sure that we are always asking the question, “How does this meeting, event, or discussion help bring others closer to God?” “How am I living out the Gospel to love one another as I encounter this person in front of me?” We can only accompany those who come forward or who are invited. All the staff and ministries of the diocese should be doors to those who might benefit and grow in their love of Christ through the Mental Health Ministry program and that was a focus as we headed into 2022.

Also during this time, the coordinator took on substantial volunteer (and some paid) work for the Association of Catholic Mental Health Ministers. The coordinator believes that to stay strong, our ministries must be connected not only to others in the diocese but also to others across the country so that our resourcing and rejuvenating stays fresh. The work that she did for the association—creating training material and spiritual support group curricula, helping to host a national mental health ministry conference and bi-monthly parish networking meetings, helping with administering grant approval and mentoring parishes who applied for funding—will help the Orange Chapter to have the tools, procedures, and resources to continue the ministry.

IMPACT OF THE MENTAL HEALTH MINISTRY PROGRAM

There are many ways to assess impact. Looking at the numbers, we have held four Mental Health Ministry Parish Team Leader Trainings that commissioned 61 lay ministers. The 61 leaders we trained started ministries in 14 parishes. We held eight Mental Health First Aid training courses that trained 124 people. Another way of assessing impact is to look at structures in place to keep the ministry going. We formed a chapter of the Association of Catholic Mental Health Ministers and have had 26 monthly meetings of our chapter ([minutes are available here](#)). Our [website of events](#) for includes a Thursday night gathering for a psychoeducational event in Spanish in Anaheim, a Saturday morning gathering to pray the rosary and support one another in Yorba Linda, and on Wednesday in Cypress there will be a family caregiver support group while in Irvine there will be a spiritual support group for persons with mental illness. The following Saturday, there is a bilingual English and Spanish Anointing of the Sick service with resources for persons with mental illness and caregivers after the service.

Holding events and training ministers helps to let others know that we are providing a space for people to share about mental health in a faith context. The event numbers give some information about impact, but there are many stories that help to show the true impact of those numbers. Some of those stories are shared next. We know that there is much more work to be done, but we do believe that because of this grant to our diocese ...

PEOPLE ARE FEELING SEEN & LOVED

One group member said, “I am so very grateful to the Church for putting on this class. It has done wonders for me. I value your support more than you will ever imagine.” Our network is starting to grow enough that we can start to catch people who are falling through the cracks and get them to local Catholics who are knowledgeable and caring. For example, a group of ministers walked at the NAMI Walk and had a resource table to tell about our ministries. A father who was concerned about his son came to the table. The minister at the table got his information and had a minister from his town call the man. She was able to listen to his concerns and pray with him and then reach out to a deacon from the man’s parish who could contact him. We were not able to get the son to come to a support group meeting, but the father and the son both know that the Church cares for them. The father choked up and expressed thanks when we prayed with him for his son.

PEOPLE ARE NOT HIDING THEIR MENTAL ILLNESS AND ARE COMING TO MINISTRY EVENTS

There is a priest in Costa Mesa, who has spoken openly about his own mental health challenges. After a recent Anointing of the Sick service, he told the Mental Health Ministry Leader at his parish that he estimated that 90 percent of the people who came for the sacrament in December 2021 did not have physical ailments but were there for their mental illness. That ministry planned to focus on mental illness at their next anointing service and added a visual reminder of mental illness to their event as well as invited community agencies to provide resources.

In August 2021, St. Anthony Claret Parish in Anaheim had a Mariachi Festival and dinner that honored health care workers and first responders and was attended by hundreds. The bilingual event was a fundraiser for their newly established Mental Health Ministry program. The event not only gathered many people together from the local community but also featured mental health and advertised that the parish now has a Mental Health Ministry program. St. Kilian Parish was an early leader in our ministry. They held monthly gatherings on mental health and faith as well as offered a series of NAMI classes.

A parishioner from a nearby parish was experiencing a mental health crisis in her family and so joined the classes at St. Kilian. The leaders at St. Kilian encouraged her to start a ministry at her home parish in the neighboring town of San Clemente. That ministry at Our Lady of Fatima Parish started and has provided a monthly spiritual support group in English. When they tabled at the parish's resource fair, they learned that there is a need for a similar group in Spanish. The ministers from Our Lady of Fatima Parish reached out to our network of ministers to fill that need and will had their first gathering in Spanish in March 2022.

CATHOLICS HAVE A SPACE FOR CONVERSATIONS ABOUT HOW MENTAL ILLNESS HAS INTERACTED WITH THEIR FAITH.

Through mental health ministry we are evangelizing. Last fall (2021), a man stopped by St. John Neumann Parish in Irvine after work. He was feeling weary and anxious and though he had not been to his home parish in a neighboring town for a couple of years, he decided to stop in the church to pray. He picked up a bulletin and

saw that the parish was starting a Grace Group. He reached out to the leader via email and attended the first session. Although he has not continued coming to the group because it is in the evening when he needs to be home, he was able to stay in contact with the Mental Health Minister via email and phone to be prayed with and to get resources. In another part of our diocese last spring, a woman was feeling sad and angry; her friend had just died by suicide. The woman was not even sure she believed in God, but she let Him know how upset she was, and she asked God, "If you are really there, show me a sign." Little did she know the signal God would give her was an actual sign in front of St. Irenaeus Church in Cypress. The sign was about a suicide prevention & awareness event at St I's. She read the sign and interpreted it as God asking her to pull over. She parked her car and went into the church to pray. At that moment, the Mental Health Ministry Team of St. Irenaeus Church was meeting on the patio. One of the ministers left the meeting and went into the church to pray with her. The woman told her story and was listened to with compassion. The minister met with her again and invited her to the Rite of Christian Initiation for Adults (RCIA). She converted to the Catholic faith and joined their parish.

PEOPLE ARE REACHING OUT TO ONE ANOTHER TO BRING OTHERS TO MENTAL HEALTH MINISTERS

A woman from San Juan Capistrano was worried about her daughter's mental health and went to a nurse where she worked in Dana Point for resources. The nurse said, "Oh, I want you to meet a minister from our parish at St. Edward Parish in Dana Point, Jill." Jill was able to meet with the woman and not only give her resources,

but also to reassure the mom that the Mental Health Ministry Team would be praying for her and for her daughter. The ministry at St. Edward Parish does not have a building right now because their parish is under construction, but they have been able to raise awareness in their parish with bulletin articles. Those bulletin articles alerted a family who had recently lost a child to suicide to seek out the Mental Health Ministers. The ministers were able to pray with the family and help support the family in a fundraiser they were doing for suicide awareness to honor their child. The minister was also able to give the family a copy of the book, *When a Loved One Dies by Suicide*.

SOME STAFF FEEL MORE COMFORTABLE TALKING ABOUT MENTAL ILLNESS AND MAKING REFERRALS EARLY

St. Irenaeus Parish had an early start on their Mental Health Ministry program by having a NAMI family support group on a bi-monthly basis but has grown even further grown their ministry even further. It has seen the ways the ministry is changing their parish and even their school. Parents at the school have been affected by stigma-lowering events at the parish and increasingly have come forward to talk with the parish nurse about accessing mental health care that understands and respects our Catholic faith. There is more work to be done to equip staff at parishes and we have plans to that effect later this year by working with the Human Resources department at the diocese.

Lessons Learned, Lessons To Pass Along

INGREDIENTS WE THOUGHT WOULD BE STRONG DRIVERS, BUT THAT DID NOT IMMEDIATELY LEAD TO MINISTRY

This ministry was re-ignited from a spark through the Adverse Childhood Experiences (ACEs, trauma) presentation and learning that the Gospel teaches us how to prevent these disruptions in family relationships. We thought that learning about the negative health effects of ACEs would galvanize parishes to use the Gospel to help one another prevent and heal from ACEs. Although ACEs galvanized some parishes, it was harder than we anticipated for groups to make the connection between neuroscience and the Gospel. So, we started making the connection between faith and mental health more directly. Understanding the impact of trauma is important, but it may not be the force that initially starts the ministry in all parishes.

We were waiting to start our ministry until all pastors received a letter from the bishop inviting them to participate. The letter did not have as big of an impact as we had hoped on recruiting parishes. What did work was meeting with people whom we knew had an interest or a passion for mental health and working with them. It may be that the pastors already knew of this bishop's support for this ministry, so that the letter did not have the initiating power we thought it would have. Nonetheless, having a bishop who strongly believes in the ministry and supports it has been critical.

INGREDIENTS LEAD TO MINISTRY

We knew that involving people who live with a mental illness diagnosis and their loved ones in leadership in the ministry would help us make the biggest impact—and it did. Some people might be hesitant to put persons with mental illness into leadership positions, but we knew they were capable and gifted and would be critical to our success. That turned out to be true. People most affected by mental illness know the challenges and how to face them better than anyone, and having persons with mental illness in our leadership has helped us to take big strides.

Having dedicated staff (even part-time) who are coordinating the ministry from a diocesan level has been key to keeping the ministry running and sharing resources across the diocese. It would be difficult to keep this ministry going without some sort of diocesan support unless the parish leadership was very dedicated to it. Also, mental health ministry is not something well known yet, so it is something that requires dedicated time and trainers.

ASSETS WE UNDERESTIMATED BUT NOW KNOW ARE CRITICAL

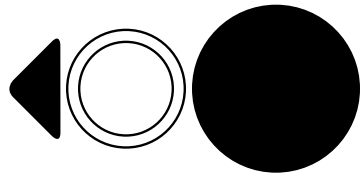
Communication and administrative support are key to success. In the modern age, there is a cacophony of messages coming at us daily. The old way of making a pulpit announcement or putting a notice in the bulletin still helps people to find us. However, it is helpful to have at least some support of persons with digital communication skills (website support, social media, graphic design) and administrative skills (database management and newsletter creation), even if it is only a few hours per month. We were able to make use of the chapter websites with the Association of Catholic

Mental Health Ministers and easily make changes to our chapter site. If I were starting this over again, I would seek communication support in the grant-writing phase. If the diocese communication department did not have capacity to support the ministry, I would write that as a budget item in the grant.

All staff and volunteers in the diocese must know about mental health ministry so that they can invite people with an interest or need to join us. At first, we focused only on the Mental Health Ministers themselves, but now we realize that everyone who works for the Church is a door to this ministry, and all need to understand stigma and how to help one another when they see a mental health challenge.

Reflection

We are joyful, connected, and creative missionary disciples. We go in pairs or trios whenever possible, and we meet as a diocesan network monthly. We encourage people to do the tasks that make them come alive and to trust that God will provide through the Body of Christ others to do the other jobs that also must be done. We believe that anyone who cares about this ministry can become a leader and will surely have gifts and talents that help the ministry. We have norms of naming and appreciating the gifts of one another and of nonjudgmentally noticing and correcting stigma when it inevitably shows itself among us. We pray to the Holy Spirit to kindle in us the fire of God's love and to send out God's creative Spirit to renew us. We share our burdens and we pray for one another.



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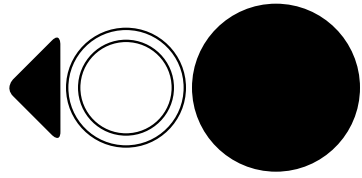
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APPENDICES

Resources, Liturgical References, and Prayers

Appendix A: Ministry Operations (p. 237)

Appendix B: Sample Devotions and Prayers (p. 247)

APPENDIX A: MINISTRY OPERATIONS

Sample Mental Health Ministry Volunteer Orientation Outline

1. Scope of the Ministry
2. Diocese Insurance Coverage
3. Training Components
 - a. Mental Health First Aid
 - i) Verification of training
 - b. Making appropriate referrals to vetted mental health providers
4. Job Description
 - a. Registered parishioner
 - b. Commissioned team members
 - c. Auxiliary members
 - d. Roles and guide for serving
5. Confidentiality (not mandated reporters)
6. Monthly Meetings
7. Resources to Know
 - a. Community agencies and organizations
 - b. Professionals and providers
 - c. Referral sites
 - d. Monthly tabling

8. Educational Workshops, Training, Presentations, Special Events
 - a. Hold at parishes
 - b. Around the diocese
 - c. Community agency-sponsored events
9. Data for Mental Health Ministry
 - a. How do you know it's working?
 - i) Annual reports
 - ii) Surveys

Sample Description of Roles, Responsibilities, and General Guide for Serving (Support Materials for Volunteers)

While there are descriptive roles and responsibilities for each member, there are no bold dividing lines. The parishioner or family requesting assistance or referred to the ministry is not only the responsibility of one person, or one group, but of the entire Ministry.

MINISTRY INVOLVEMENT

Team members are expected to attend scheduled meetings and required educational program. The Ministry understands personal and family responsibilities that may conflict with the Mental Health Ministry schedule. It is helpful when known absence is shared with the Mental Health Ministry Coordinators in advance so that members can plan accordingly.

All members have God-given talents, and some have more time than others; please share as much as you can.

COMMUNICATION

Members are expected to read emails and are asked to acknowledge receipt, especially when help is needed for some tasks or projects. If not available or unable to help, please say so in a timely manner, so team can plan accordingly.

CONFIDENTIALITY

It is expected that all ministry members observe strict confidentiality, and discusses Mental Health Ministry issues

formally in private at all times. Sending emails from a personal, non-HIPPA compliant account with individuals' and families' personal information and assistance requests is prohibited.

SAMPLE MENTAL HEALTH MINISTRY PLANNING CALENDAR

MONTH	ACTIVITY
JANUARY	1. Ministry General Meeting 2. Mental Health Ministry Resource Table 3. St. Dymphna Prayer Group
FEBRUARY	1. Mental Health Ministry Resource Table 2. Ministry General Meeting 3. Food for Families 4. St. John of God Prayer Group
MARCH	1. Mental Health Ministry Resource Table 2. Ministry General Meeting 3. NAMI speaker 4. Our Lady of Lourdes Prayer Group
APRIL	1. Mental Health Ministry Resource Table 2. Ministry General Meeting 3. Educational Event/speaker

	4. St. Benedict Joseph Labre Prayer Group
MAY	1. Mental Health Ministry Resource Table 2. Ministry General Meeting 3. Community Event 4. St. Dymphna Prayer Group/Feast Day May 15
JUNE	1. Mental Health Ministry Resource Table 2. Ministry General Meeting 3. Outreach 4. St. John of God Prayer Group
JULY	1. Mental Health Ministry Resource Table 2. Ministry General Meeting 3. Community Event 4. Our Lady of Lourdes Prayer Group
AUGUST	1. Mental Health Ministry Resource Table 2. Ministry General Meeting

	3. “Conversations Over Breakfast” 4. St. Benedict Joseph Labre Prayer Group
SEPTEMBER	1. Mental Health Ministry Resource Table (Check your Mood screening) 2. Ministry General Meeting 3. Educational Event 4. St. Dymphna Prayer Group
OCTOBER	1. Mental Health Ministry Resource Table 2. Ministry General Meeting 3. Community Outreach 4. Educational Event
NOVEMBER	1. Mental Health Ministry Resource Table 2. Ministry General Meeting 3. Educationally event 4. St. John of God Prayer Group
DECEMBER	1. Mental Health Ministry Resource Table 2. Ministry General Meeting

	3. Outreach 4. Our Lady of Lourdes Prayer Group
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Sample Mental Health Ministry Bulletin Announcement

MENTAL HEALTH MINISTRY

Our parish is a member of the Diocesan Mental Health Ministry Network, whose mission is to bring Christ to families experiencing mental health challenges. Individual mental health ministry team members are available to meet and confidentially talk with individuals and families needing support. Ministry members are familiar with the many public and private support services available to families in their local communities and will help families locate suitable providers. Our mental health ministry exists to serve individuals and families experiencing mental illness by offering God's hope and love through encouragement, practical support, and prayer.

If you or a family member are experiencing mental health challenges, please contact a Parish Mental Health Ministry member. You may also contact the Crisis Line (*number in your area*) 24 hours a day/7 days a week.

APPENDIX B: SAMPLE PRAYERS & DEVOTIONS

Saint Dymphna, Patron for Those with Mental Illness

Lord, we Pray for those who have a Mental Illness

Help us understand that the way we talk about people with a mental illness affects the people themselves and how we treat the illness. So often people who have a mental illness are known as their illness; people say that “she is bipolar” or “he is schizophrenic”; when we talk about mental illness we should not use that phrase. People who have cancer are not cancer; those with heart disease are not heart disease. Let us always remember that people with a mental illness are not the illness—they are beautiful creations of God.

There is so much fear, ignorance and hurtful attitudes that the people who suffer from mental illness needlessly suffer further. Help us to support and be compassionate to those with a mental illness, every bit as much as we support those who suffer from any other illness.

Grant courage to those for whom we pray and fill them with hope. If it is according to Your Divine Will, grant them the recovery and cure they desire. Help them to remember You love them; they are never alone.

***Saint Dymphna, Patron of those with a Mental Illness, pray for
us.***

Prayer to Saint John of God

St. John of God,

patron of the sick and compassionate Brother

to all who suffer or are troubled in any way,

I turn to you with great confidence in my time of need.

I ask you, John, to speak to Jesus on my behalf.

He will listen to you because you tried to be like Him

in the compassion and love you had for people in need.

I know only Jesus can really help me,

but I also know that He can be influenced by someone close to Him,

I plead with you, Brother John,

to present this special intention of mine to Jesus

so that He may grant it, according to His will(mention the intention).

Help me, John, to strengthen my faith, my hope, and love

for Jesus and our Mother Mary,

for whom you had such a special love.

All glory to the Father, Son, and the Holy Spirit.

Amen.

Prayer to Saint Benedict Joseph Labre

St. Benedict Joseph Labre, you gave up honor, money, and home for love of Jesus. Help us to set our hearts on Jesus and not on the things of this world. You lived in obscurity among the poor in the streets. Enable us to see Jesus in our poor brothers and sisters and not judge by appearances. Make us realize that in helping them we are helping Jesus. Show us how to befriend them and not pass them by. St. Benedict Joseph Labre, you had a great love for prayer. Obtain for us the grace of persevering prayer, especially adoration of Jesus in the Most Blessed Sacrament. St. Benedict Joseph Labre, poor in the eyes of men but rich in the eyes of God, pray for us. Amen.

Prayer for those with Mental Illness

Lord, we pray for those who have a mental illness and those who love and care for them.

So often people who have a mental illness are known as their illness. People say that “she is bipolar” or “he is schizophrenic.” When we talk about people who have a mental illness, we should not use that phrase. People who have cancer are not cancer; those with diabetes are not diabetes. People with a mental illness are not illness—they are beautiful creations of God.

The way we talk about people and their illnesses affects the people themselves and how we treat the illness. In the case of mental illness, there is so much fear, ignorance, and hurtful attitudes that the people who suffer from mental illness needlessly suffer further.

Our society does not provide the resources that are needed to adequately understand and treat mental illness. Even with the best medical care available, always taking the cocktail of medicines that are prescribed and doing their best to be healthy and manage this illness—for too many—that is not enough. Someday a cure will be found, but until then, we need to support and be compassionate to those with mental illness, every bit as much as we support those who suffer from cancer, heart disease or any other illness.

All too often, our loved ones who had a mental illness died from suicide. They were sweet, wonderful people who loved life, the people around them—and had faith in you. Eternal rest grant unto them, O Lord, and may perpetual light shine upon them.

Amen.

Prayer of Petition for Those with a Mental Illness

We remember and pray for those who have a mental illness and those who love and care for them.

The way we talk about people and their illnesses affects the people themselves and how we treat the illness. In the case of mental illness, there is so much fear, ignorance, and hurtful attitudes that the people who suffer from mental illness needlessly suffer further. We ask God that the fear be turned to love, the ignorance be turned to wisdom, and the hurtful attitudes be turned to compassion—we pray to the Lord: **“Lord hear our prayer.”**

So often people who have a mental illness are known as their illness; people say that “she is bipolar” or “he is schizophrenic.” When we talk about people who have a mental illness, we should not use those phrases. People who have cancer are not cancer; those with diabetes are not diabetes. People with a mental illness are not the illness—they are beautiful creations of God. We ask God to help everyone to see them for their goodness, their strength, and their beauty—we pray to the Lord: **“Lord hear our prayer.”**

Everyone who has a mental illness has a right to the best therapy and medical care available. We ask God that those with a mental illness be encouraged and supported in their efforts to be healthy and manage their illness—we pray to the Lord: **“Lord hear our prayer.”**

All too often, the medical care that is available is not enough, and far too many people suffer. Our society does not provide the resources that are needed to adequately understand and treat mental illness. We ask God to change our society and to give wisdom to our leaders so that every single person suffering from mental illness will

receive all the care they need—we pray to the Lord: **“Lord hear our prayer.”**

We believe that someday—someday—cures will be found, but until then, we ask God to help us to support and be compassionate to those with mental illness, every bit as much as we support those who suffer from cancer, heart disease, or any other physical illness—we pray to the Lord: **“Lord hear our prayer.”**

All too often, our loved ones who had a mental illness died from suicide. They were sweet, wonderful people who loved life, the people around them—and had faith in you. Eternal rest grant unto them, O Lord, and may perpetual light shine upon them—we pray to the Lord: **“Lord hear our prayer.”**

