Task Force on Individuals with Mental Illness

Members

The Rev. Dr. David Gortner, Chair	Spokane, VIII	2024
Dr. Brandon Beck	West Texas, VII	2024
Ms. Megan Carlson	North Carolina, IV	2024
Mr. Luis Collazo Lugo	Puerto Rico, II	2024
Mr. Billy Cottrell-Jackson	Southwest Florida, IV	2024
Dr. Adrianne Duvall	Dallas, VII	2024
The Rev. Jedediah Fox	Olympia, VIII	2024
Mr. Jeffrey Kincaid	Milwaukee, V	2024
The Rev. Myra Kingsley	Arizona, VIII	2024
The Rt. Rev. Kevin Nichols	Bethlehem, III	2024
Mrs. Tammy Pallot	Atlanta, IV	2024
The Rev. Deacon Susan Phillips	Delaware, III	2024
The Rev. Matthew Simpson	Maine, I	2024
The Rev. John Stewart	Alabama, IV	2024
Ms. Liz Wendt	Pennsylvania, III	2024
Ms. Julia Ayala Harris, Ex Officio	Oklahoma, VII	2024
The Most Rev. Michael Curry, Ex Officio	North Carolina, IV	2024

Changes in Membership

Jeffrey Kincaid withdrew from membership in the first year. Billy Cottrell-Jackson withdrew in May of 2023 due to family health concerns.

Representation at General Convention

Deputies Megan Carlson (NC), Liz Wendt (Penn), David Gortner (Spokane), Tammy Pallot (Atlanta), the Rt. Rev. Kevin Nichols (Bethlehem) are authorized to receive non-substantive amendments to this Report at the General Convention.

Acknowledgments

Thank you to our new class of Instructors for Mental Health First Aid for Adults. You will be a valuable resource for the church in the next Triennium.

Thank you to everyone that volunteered as a potential instructor. We have saved your names and look forward to getting you trained in the near future.

Mandate

2022 - A110 Continuation and Expansion of Task Force on Ministry to Individuals with Mental Illness

Resolved, That the 80th General Convention continue The Task Force on Ministry to Individuals with Mental Illness, in order to aid in the direction and development and provision of resources, trainings, and curricula in pastoral and ministerial mental health care for The Episcopal Church, its provinces, dioceses, parishes, seminaries, schools, and affiliated organizations, among all of its bishops, priests, deacons, and parishioners; and be it further

Resolved, That The Task Force on Ministry with Individuals with Mental Illness be expanded to eighteen in its membership that represents a depth and range of professional, personal, familial, and organizational experience with mental illness, in order to successfully develop and provide aforementioned resources, trainings, and curricula;

Resolved, That the Task Force on Ministry with Individuals with Mental Illness, in its expanded version in conjunction with its development of and provision of aforementioned trainings, will develop and share resources for The Episcopal Church, its various organizations, and all of its people centered on pastoral and ministerial mental health care; and be it further

Resolved, That this expanded Task Force report back on its actions to the 81st General Convention; and be it further

Resolved, That the 80th General Convention request that the Joint Standing Committee on Program, Budget, and Finance consider a budget allocation of $21,700 to complete resources for church-wide distribution and use by the next triennium.

2022-A107 - Ministry with People with Mental Illness and Their Families

Resolved, That the 80th General Convention of The Episcopal Church recognize the worldwide prevalence of mental illness and the need for effective ministry with people facing mental health challenges, and the need to continue the work begun with the General Convention resolutions 2015-C020 and 2018-C034; and be it further

Resolved, That The Episcopal Church now equip all its people, both clergy and laity, to interact in compassionate, competent ways with those experiencing mental health challenges; and be it further

Resolved, That the provinces and dioceses of The Episcopal Church utilize resources to strengthen care, inclusion, support, and advocacy for all people (both laity and clergy) who struggle with mental health challenges; and be it further

Resolved, That the provinces and dioceses of The Episcopal Church support the mental health of their clergy by advocating for clergy to be intentional about their self-care, and realizing that clergy, like anyone else, may also struggle with challenges to mental health.

2022-A108 - Training of trainers for Episcopal Provinces in Mental Health First Aid

Resolved, That the 80th General Convention authorize launch of training people in dioceses, congregations, schools, seminaries, and other entities of the Episcopal Church in the forming of caring relationships with people with mental illness and their families, in recognizing possible mental health crises and interacting in healthy and supportive ways with people in crisis, and in advocacy and bridge-building support, using the resources and training processes of Mental Health First Aid and the National Alliance on Mental Illness, as well as the Interfaith Network on Mental Illness, WISE for Mental Health, and other helpful organizations and networks; and be it further

Resolved, That the 80th General Convention authorize and fund the training of at least 15 regional trainers in Mental Health First Aid (MHFA) for the sake of providing basic MHFA training in the Provinces of the Episcopal Church, drawing as well upon the expertise of MHFA trainers who are part of the Union of Black Episcopalians along with other Episcopal MHFA trainers, with training to be completed by May 2024, so that they will become available as resource trainers for the dioceses in each Province; and be it further

Resolved, That the 80th General Convention recommend training in Mental Health First Aid and general awareness of mental health and illness for all active clergy and lay staff in the church entities of each diocese, with issuance of certifications; and be it further

Resolved, That the 80th General Convention request that the Joint Standing Committee on Program, Budget, and Finance consider a budget allocation of $35,000 to help fund the training of the regional trainers for the Provinces.

2022-A109 - Developing Curriculum and Required Training for Clergy in Mental Health Pastoral Care

Resolved, That the 80th General Convention authorize the creation and launch of new curriculum to train all Episcopal ordained clergy, candidates, and postulants in mental health and mental illness awareness that emphasizes pastoral care, the forming of caring relationships, and effective advocacy. This new curriculum will incorporate and expand upon a range of resources including Mental Health First Aid, the National Alliance on Mental Illness, the Interfaith Network on Mental Illness, WISE for Mental Health, and other helpful organizations and networks; and be it further

Resolved, That it is recommended that all those to be ordained from January 2024 onward be trained in this new curriculum that will include training in Mental Health First Aid and in the advocacy work of the National Alliance on Mental Illness; and be it further

Resolved, That the 80th General Convention recommend the training of all active priests, deacons, and bishops in this curriculum for mental health and mental illness awareness; and be it further

Resolved, That the 80th General Convention request that the Joint Standing Committee on Program, Budget, and Finance consider a budget allocation of $15,000 to support curriculum development for this training of clergy.

Summary of Work

Executive Summary of the Task Force Work

Mental health and wellness affects every province, diocese, ministry setting, and person. Individuals with mental illness are among the most marginalized in the world as it is made up of people from all walks of life and all communities. Mental illness can affect anyone regardless of social standing, geography, race, or gender identity. Our work in this abbreviated triennium highlighted the need to prioritize ministry related to mental health.

The continuing Task Force on Individuals with Mental Illness took resolution 2022-A110 as its overarching directive: to develop and provide resources, trainings, and curricula on mental health to be shared with the Episcopal Church, in order to increase awareness, improve pastoral care, and strengthen basic capacities that foster welcome, inclusion, support, and advocacy. This primary mandate became the basis for work outlined in the other secondary resolutions.

Resolution 2022-A107 called for the Episcopal Church to take up the mantle of responsible care, support, and advocacy for mental health. The call to the church was to equip lay and ordained people with skills and tools for compassionate, competent interaction with people experiencing mental illness and mental health challenges. This resolution echoed prior resolutions from the past decades but with greater emphasis on taking action.

Resolution 2022-A108 spelled out a clear direction for training and equipping people in the church with skills for caring interaction with people experiencing a wide range of mental health challenges, including people experiencing crisis. The resolution pointed specifically toward recruiting, training, and deploying a small set of Episcopalians, spanning the Provinces of the Episcopal Church, as instructors in Mental Health First Aid (MHFA).

Resolution 2022-A109, the resolution calling for the development of a deeper curriculum for clergy, was proposed by the prior Task Force and taken up as work by this Task Force. The Task Force produced a curriculum for all active clergy and postulants, with a first foundation of training in Mental Health First Aid.

The Task Force's work yielded six resources for building awareness and basic skills in spiritually grounded care and support for people with mental health challenges, recruited, trained and deployed eleven MHFA instructors from eight of the nine Provinces of the Episcopal Church, and drafted a robust curriculum for increased knowledge and skill for clergy and lay leaders. From this work and the rapidly rising incidence of mental illness across the globe in recent years, it became clear that the

Episcopal Church must emphasize continuing growth in basic competency in Mental Health First Aid. The newly trained MHFA instructors, joining with other Episcopalians already certified as MHFA instructors, have begun to provide one-day MHFA courses for congregations, schools, camps, diocesan gatherings, clergy gatherings, and church networks to equip people with these foundational skills for recognizing potential mental health crises and challenges and for interacting in helpful ways. Hundreds of people will have received this basic training by the 81st General Convention in the summer of 2024.

Continuing forward with the goals set in Resolution 2022-A109, The Task Force urges the Episcopal Church to move toward requiring Mental Health First Aid as training on par with Safe Church and Racial Reconciliation training. The Task Force has proposed a resolution urging MHFA training for all active clergy, postulants, candidates, and lay members in senior leadership positions. Given the enduring importance of ministry with people with mental health challenges and given the sporadic and disparate attention to matters of mental health as well as physical health in varied Task Forces over decades, this Task Force has urged the creation of an enduring Standing Commission for Human Health and Wellness, supported consistently with funding for continued development and deployment of resources and training that support the church's ministry related to mental and physical health.

The Task Force completed the vast majority of the aims and initiatives set out in Resolutions A107-A110. It is also clear that further work is needed to ensure continuing development of the church's capacity in welcoming, including, supporting, encouraging, empowering, and advocating with people who face mental health challenges. The Task Force has completed its set tasks as a significant first step in what must be ongoing work of the church.

The future of the work that has been completed here depends upon the church's continuing efforts to grow in its ministry in relation to mental health. Resolutions brought forward by the Task Force for the 2024 General Convention aim toward such churchwide affirmation of continuing growth across all orders of ministry, specifically in mental health ministry, and more broadly in integrated holistic ministry of health and human wellness.

Detailed Summary of the Task Force Work

General Overview of the Task Force Goals and Work Plan

The Task Force on Individuals with Mental Illness began our work online in mid-January with a data dump of all the material and resources that the Task Force accomplished during the 2018 – 2022 triennium cycle. New members of the Task Force were invited to review this material in advance of our first meeting in February 2023.

At the first meeting, this triennium's Task Force reviewed the history of the past triennium's Task Force, expressed individual's goals for involvement, and started to establish a work plan for this shortened triennium. Based on the prior work of the Task Force and the resolutions that were passed at the 80th general convention, the group knew there were three primary task to accomplish:

- Resource development and deployment
- Training development and deployment
- Curricula development and deployment

This division of tasks would be instrumental in achieving the underlying mission and vision of our membership, specifically:

- to increase awareness of mental illness, its prevalence, and the need for effective ministry;
- to equip all clergy and laity in dioceses, congregations, schools, seminaries, and other entities of the Episcopal Church to interact in compassionate, competent, and supportive ways with people with mental health challenges;
- to strengthen care, inclusion, bridge-building support, and advocacy/stigma-reduction for people with mental illness in Church settings and beyond, for clergy and the whole Church; and
- to advocate for clergy to be intentional about their own mental health and self-care.

Early in our time together, the group were fortunate to be able to meet as part of the Interim Bodies meeting in Cleveland at the end of March to begin the bulk of our work in each of these three priority tasks. The team were rocked during this time by a crisis regarding budgetary support of our mandate. Following a very quick panic, the team pivoted first to identifying external means of funding and then back to condensing our work plan once funding was secured from the General Convention Office. During the intense 60 hours, the team broke into sub-groups for each of the planned tasks. The Training group was tasked with bringing a planned training of Instructors in Mental Health First Aid – Adult (MHFA-A) under the constraints of our new budget. The Resource group laid out a plan for resource production for faith communities outlining best practices on key topics. Lastly, given the availability of members, the Curriculum group setup an outline that could be examined and discussed by all members of the Task Force during our time together.

By the end of our time in Cleveland, the group had a clear plan for the next 8 months. The Task Force setup a general cadence of meetings monthly online via Zoom. Each sub-group would work independently on their task between meetings. The meetings became a time to share the progress each sub-group was making to get feedback from the other group. This allowed each group to work at the appropriate pace for their task, which was helpful for our training group which was coordinating

schedules with many diverse individuals and groups to pick an advantageous time to train our Episcopal Church Instructors.

That time was determined to be in conjunction with a second Interim Bodies meeting at the end of October (a few weeks after the majority of the Interim bodies). For the first part of the week, eleven volunteers from 8 of the 9 Provinces were trained as instructors for Mental Health First Aid (MHFA). The second half of the week was spent working intensely to put the finishing touches on the resource documents and curriculum. These finalized documents are included in the supplemental section of this report. The last task of the group was to put into motion through the writing of resolutions to continue the work of the Task Force for the next triennium and beyond.

The Task Force proposes the creation of a Standing Commission to provide stability and sustainability for the Episcopal Church to minister to individuals with mental illness and to grow the mandate to encompass all facets of health and wellness, including physical, mental, emotional, relational, and spiritual facets of life. The Task Force is proposing some additional resolutions for the next triennium based on the needs about which the group heard during the work of this triennium.

Challenges and Lessons Learned:

The Task Force had a few challenges along our way to accomplishing our work. But with God's help, the team overcame. The shortened triennium focused our work on our goals when many other possible avenues and activities might have otherwise pulled our attention. The work for and with individuals with mental illness and the caregivers that support them have a diversity of needs before considering the diversity of the population affected. The group focused on laying a cornerstone during this triennium that could support the work of future bodies.

As previously alluded to, the Task Force also encountered issues with funding early in our work. Although a few of the resolutions the group took as our mandate included budget request, the money was not guaranteed. The group reviewed the possibility of external funding, specifically looking at grants from the US federal government and other church grant foundations. As a task force of general convention, grant funding is exceedingly difficult to process given our ephemeral life. This knowledge of funding would facilitate our resolution writing for the 81st general convention. The Task Force has ensured that any funding needs were clearly asked of the Budget committee to make a best effort to secure funding moving forward. The group have also begun conversations with various departments in the Episcopal Church to understand their capacity to receive outside funding to extend the Mental Health work further.

Another challenge came in the form of external limitations due to a limited budget. MHFA has three primary offerings: Adult, Youth, and Teen-2-Teen. Early in our work, the team hoped that a joint training course to cover both Adult and Youth Aid could happen, but the Certifying organization was not prepared to offer the dual certification on our timeline. [The Task Force continues to be in conversation with the certifying organization to help advocate for dual certification training.] The group voted to pursue MHFA instructor training for the Adult module. Given the current demographics of the church and a general understanding that except for a few specific instances, the Adult module seemed most applicable as a starting point. The team has written resolutions with funding request to ensure that in the next triennium, the church can train instructors in all three courses. While this is good for the future, it meant that many of our identified instructor candidates chose not to be trained as an Adult Instructor. [The Task Force will have their names to pass along to the next body to take up this work.] Finally, as it regards training, the group utilized an in-person private instructor course to save money on a bulk training session. This added a complication to our candidates' decision to complete the course. The training time, demand for being gone for a few days, and schedule changes for training dates again led to a drop-off in eligible candidates. Eleven new instructors were trained and are eager to start work in offering MHFA training in their provinces, many beginning to offer trainings in early 2024. And all those candidates originally identified are ready to be trained as instructors in Adult or Youth modules as soon as General Convention is over, and funding is made available to support instructor training.

Another external limitation is the reach of Mental Health First Aid in Province 9. MHFA is international in its reach but has clear standards about abiding by laws and ordinances governing its approval in each independent nation. This resulted in limits set on who could function as trained instructors in their own countries. The committee hopes that these barriers can be addressed effectively in the next few years. There were also the internal limits within the committee in terms of its member composition. There was a strong range of direct personal and professional experience with mental health challenges, but there was limited variation in cultural and racial contexts represented among committee members. The group strove to hold in mind siblings in Christ with different lived experiences and to honor their traditions and needs regarding mental health. It is the genuine prayer of this group that as this work grows, its leadership will include the full body of Christ. Our work was consistently informed by the earlier (and continuing) work by the Union of Black Episcopalians and the articles and resources they have produced. The group anticipates translation and cultural adaptation of the documents produced, but also recognizes that this is not enough. The group asks for the continuance and growth of this work with greater attention to diversity in composition of the proposed Standing Commission.

Finally, although the group gives thanks to Zoom and Microsoft Teams for enabling work across vast distances, they did still pose a challenge. Teams can be simple to use once you know how to use the platform, but a learning curve exists. For individuals with iOS or Linux operating systems, the

technology became a barrier to inclusion. Zoom is great for facilitating conversation, but not so great for document production. The majority of the work on Curriculum and Resource documents was completed during our two interim body meetings over 150 hours together. The team would work from 8:30 in the morning until 10:00 at night to put our hearts into the work product. Our recommendation for the future is to front load interim body meetings, as Zoom and Teams work better over long distances after community building has happened and when the intention is editing, revision, and discussion of documents and topics.

Sub-Committee on Creating a Mental Health Curriculum

The Curriculum Group for clergy curriculum development and deployment built and expanded upon the work done in resource and training development. A109 called for the creation and launch of a new curriculum to train all Episcopal ordained clergy, candidates, and postulants in awareness that emphasizes pastoral care, the forming of caring relationships, and effective advocacy – including training in basic MHFA and NAMI advocacy.

Unbeknownst to this Task Force, A109 was assigned to the Standing Commission on Formation. Thus, the Task Force's Curriculum Group worked intently on developing a robust outline for clergy training in mental health ministry. The outline included nine key areas for clergy training in addition to Mental Health First aid training certification:

1. Mental Health First Aid (MHFA) training certification
2. Helpful and Unhelpful Theological / Biblical Frames and Spiritual Practices
3. Individual Pastoral and Spiritual Care, and Discernment of Concerns
4. Family Pastoral and Spiritual Care, and Discernment of Concerns
5. Community Inclusion for Individuals with Mental Illness and Their Families
6. Care for Community in Balance with Individuals' Mental Health/Illness
7. Self-Recognition, Self-Review, Self-Restoration, Self-Resilience, Self-Strength
8. Response to trauma in the wider community
9. Establishing Resource Connections in One's Community
10. Alliance and Advocacy

This curriculum outline, including scope and sequence, was designed with the potential of being launched as a hybrid course combining online and in-person sessions.

After developing the outline into a full draft of topics, themes, and core content for each area, the Curriculum team sought high-quality resources and publications to provide rich content for the ten key

areas above. These resources support curricular goals of facilitating more profound training in awareness and knowledge about mental illness, pastoral care, caring relationships, supportive bridge-building, empowerment, and effective advocacy for those with mental illness and their families, along with congregational care and clergy self-care – with foundational theological and spiritual underpinnings.

During this same time period, the Standing Commission had assigned A109 to its own subcommittee, but not much progress was made. In early Autumn of 2023, representatives from A109 Curriculum Group from the Task Force and the Standing Commission's subcommittee met online to discuss progress and potential of collaboration. Standing Commission representatives were grateful for the work done so far by the Task Force and more than happy to partner with the Task Force in further developing the curriculum. The primary contact with the Standing Commission, from Province IX, indicated interest in facilitating translation and cultural adaptation of the curriculum.

The Curriculum Group met its goal of creating a curriculum plan (attached to this report). Implementation of this curriculum depends upon the next critical steps of creating an instructional module for each key area of the curriculum, translating and culturally adapting materials for Spanish-speaking communities, and deploying MHFA instructors to train clergy in MHFA as a first step.

Sub-Committee on Mental Health First Aid Training

The Training Group embarked on a comprehensive mission to muster, train, and deploy Mental Health First Aid (MHFA) instructors throughout the Episcopal Church. The first step in the process was to compile a list of existing certified MHFA instructors within the Episcopal Church. The group began by emailing diocesan offices, requesting the names of individuals holding MHFA instructor certification. Additionally, the group took advantage of the online community by posting in multiple Episcopal Facebook groups, seeking the names of certified MHFA instructors. These efforts garnered several names; however, the list is likely not comprehensive or inclusive of all certified instructors within the church.

The next phase of the group's work was soliciting individuals to train as MHFA instructors. The group actively sought referrals from diocesan offices to identify potential candidates, leveraging their connections within the Episcopal Church. Moreover, the group reached out to the broader Episcopal community by posting inquiries on various Facebook pages to gauge interest from individuals wishing to become MHFA instructors. The group's efforts also extended to collaborating with Episcopal Camps and Conference Centers, who proved instrumental in recruiting potential instructors by featuring information about MHFA instructor training in their newsletters. Furthermore, the Association for Episcopal Deacons played a significant role in the process by disseminating the request for trainer candidates across their diverse networks. Through these collective efforts, the group received an

impressive response, amassing a list of 60 individuals who were potentially suitable candidates for MHFA instructor training.

After much discussion, the Task Force developed the following expectations for those receiving MHFA Instructor training.

- Attend every day of MHFA training and complete all assignments.
  - Attend in-person training for three days.
  - Complete all pre-work, evaluations, and post-course registration as an instructor.
- Fulfill all MHFA requirements for Instructor Certification:
  - Teach three one-day courses each year.
  - If dually certified (adults and youth), at least one course per year must be in each certification.
  - Fully utilize the process outlined by MHFA for enrolling participants, collecting fees, obtaining and distributing materials, and offering instruction.
    - Materials must be ordered from MHFA and paid for within 30 days of each training. Fees are directly reimbursable to the instructor directly from participants or through intermediary assistance from the diocese/network.
- Fulfill the following minimum expectations for the Episcopal Church
  - Commit to providing MHFA courses for at least five years.
  - Provide at least 3 MHFA courses per year specifically for the Episcopal Church with a minimum of 10 participants at each course.
  - Offer at least one class per year outside one's home diocese.
  - Courses for the Episcopal Church will be free for at least the first two years (or the first six courses, whichever comes first). After the initial two years (or six courses), the maximum compensation for courses provided to the Episcopal Church shall be no more than $300 per course.
    - It is always appropriate to request travel expenses, including room and board. Keeping compensation to a minimum radically reduces individual registration fees.
    - When providing additional courses for communities outside the Episcopal Church, charging the recommended MHFA instructor fee is permitted.
    - The goal of the courses offered for the Episcopal Church is to provide education for as many Episcopal clergy and laity as possible. If the class has not reached capacity, ecumenical partners and individuals from the wider community are welcome to attend.
  - Always notify the diocesan, provincial, or network office of training being offered. Promote and recruit, in partnership with diocesan staff, congregations, and organizations.
  - Provide a list with the contact information of all attendees to the Episcopal Church Task Force on Individuals with Mental Illness and to the sponsoring diocese/network.

- Immediately report any serious issues or problems that arise during training to the chair of the Episcopal Church Task Force on Individuals with Mental Illness and the pastorally responsible diocesan/network leader.

Once those interested in becoming MHFA instructors agreed to fulfill the expectations, the Task Force determined how many people were interested in being certified in Adult MHFA, Youth MHFA, or both. In this step, it was encouraging to see that most respondents expressed interest in being trained in both Adult and Youth MHFA.

The training group explored the possibility of having Adult MHFA Instructor training combined with the Youth MHFA Instructor training for a week-long event. MHFA was not able or willing to combine the two courses. After combining the two courses was not an option, the training group hoped to be able to provide the Adult MHFA Instructor training and the Youth MHFA Instructor training immediately following to enable those who wanted to be trained in both programs to do so in one week. Unfortunately, this was not an option because each training event lasts three days, and MHFA Instructors do not work on the weekends.

Due to funding limitations, the Task Force faced a difficult decision regarding the type of MHFA Instructor training they could offer. Although the original intention was to provide both Adult and Youth MHFA instructor training, the financial constraints prevented this from being feasible. Upon realizing this, the Task Force carefully evaluated the situation and determined that providing the Adult MHFA instructor training would be the most advantageous given the higher number of individuals working with adults in various capacities in the Episcopal Church. Moreover, the Task Force recognized that there are existing programs like Keep Watch by the Diocese of Atlanta, which focus specifically on youth mental health and would serve as a valuable resource until additional funding becomes available for further training. By prioritizing Adult MHFA instructor training, the Task Force aimed to maximize the reach and impact of their efforts while also considering alternative options for supporting the mental health needs of youth.

The Task Force originally planned to host the MHFA Instructor training at the Kanuga Conference, Camp, and Retreat Center; however, it was more cost-effective to host the training at the Maritime Conference Center due to previous contractual agreements with the Episcopal Church. The Task Force coordinated between the General Convention Office and Mental Health First Aid to host an Adult Mental Health First Aid Instructor Training October 23 – 25 at the Maritime Conference Center.

After communicating the training dates, 12 individuals expressed their interest in attending the instructor training. Unfortunately, one person encountered a family medical emergency and could not participate as planned. As a result, on October 25, 11 individuals from 8 different Provinces completed the certification process and became certified Mental Health First Aid Instructors. In addition, the chair of the Task Force is also a certified instructor, and the group has identified other trained instructors in

the Episcopal Church who are willing to coordinate efforts. This has yielded an initial total of 15 trained instructors agreed to deploy their efforts for the church.

During the training, participants expressed keen interest in being certified as Teen MHFA instructors. This program directly teaches teens in grades 10-12, or ages 15-18, how to identify, understand, and respond to signs of mental health and substance use challenges among their friends and peers. The Task Force hopes to be able to offer this valuable training in the next triennium.

Sub Committee on Resource Creation

The Resource Group began its work with access to resource drafts from the prior Task Force as a starting point. The initial goal for resource development emerged from a desire to complete prior Task Force work on generating one-page resource guides related to specific mental disorders. The list of such desired resources was lengthy, as follows:

Overview of mental illness	Schizophrenia
Trauma and its consequences	Bipolar Disorder
Stigma and Other Barriers	Substance Abuse
Depression	Eating Disorders
Anxiety Disorders	Attention Deficit Hyperactivity Disorder

Additional possible topics were also considered, but these were starting points.

However, as the Resource Group met together, they considered the specificity of the topics above to be overly diagnostic. One of the core themes in both Mental Health First Aid (MHFA) and the National Alliance on Mental Illness (NAMI) is the importance of leaving diagnostic work to the professionals and assisting the public in a more general familiarity with the realities of mental health challenges and mental illness.

The Resource Group began to pivot in this direction prior to the Task Force's first in-person meeting in Cleveland, during months of online work together. In Cleveland, this pivot took shape in the form of completely new resource documents. Some resources from the prior drafts were used. However, these new documents focused not on the diagnosis of a person with mental illness but instead on the wider faith community responding to people experiencing any kind of mental health crisis or enduring challenge.

The first step was to identify the six focus areas for development into resources. The Resource Group identified the following areas:

General Overview of Mental Health and Illness	Care of Caregivers
Individuals in Mental Health Crisis	Care of Congregations
Individuals with Persistent Mental Illness	General Resources (national and local)

The Group sketched the consistent outline for the six resources. Each document was to include these elements:

- Introduction to the issue
- A parable illustrating the topic and offering a view into the experience.
- Best practices for approaching, accompanying, and responding to a person in distress.
- Spiritual resources, including liturgical and personal prayers, scriptures, and hymns.

When the group left Cleveland, three of the documents were 70% complete with the other three in draft outline. Over the summer, the group socialized the documents with faith groups in our communities to refine the content to be the most impactful and to build excitement for their publication.

At the October 2023 meeting in at the Maritime Center in Linthicum Heights, MD, the entire Task Force came together to complete, refine, and format all the resource documents. These print-ready documents are included in the appendix of this report and will be shared more broadly at General Convention.

Thanksgiving and Spotlight of Groups Doing Good Work in Mental Health

The Task Force is grateful for all of the congregations, schools, dioceses, networks, and faith communities across the Episcopal Church who have paved the way and set the foundations for our ministry with people with mental illness.

The Union of Black Episcopalians has done tremendous work in providing multiple MHFA trainings for its members and producing an excellent resource guide for ministry with people with different mental illnesses (*A Resource Booklet for Mental Health and the Spirit*).

In previous decades, the Episcopal Mental Illness Network (EMIN) provided resources online and worked to raise church-wide awareness regarding mental health and mental illness. Their work emerged with funding from General Convention, as launched in 1991 with Resolution D088

("Encourage Understanding of Mental Illness and Respond to the Needs of the Mentally Ill") that urged the Episcopal Church toward increased awareness, inclusion, and wisdom in pastoral support of people with mental illness and their families, equipping of clergy for more informed mental health ministry, partnerships with mental health organizations, and advocacy for better mental health care. The work continued through Resolution 2000-C032 ("Urge Congregations to Commend and Support Mental Health Support Groups"), which nudged Episcopal congregations' relationships with NAMI and other mental health networks. Financial support for EMIN arose and continued through funds given to the Task Force on Accessibility of that era.

Initial efforts from the Diocese of Delaware in 2015 requesting the Episcopal Church to focus more on mental illness helped spark the efforts leading to the first Task Force in 2018.

"Keep Watch" in the Diocese of Atlanta is an example of a church-based program focused on suicide prevention that is emerging across the church.

The Diocese of Pennsylvania has been working on decreasing the stigma of mental illness through several initiatives including offering training in Mental Health First Aid as well as various different house church programs to assist people in meeting them where they are.

Recently, the Diocese of Puerto Rico opened the St. Luke's Behavioral Health Center, provide specialized medical care and address mental health challenges throughout Puerto Rico, using a holistic approach that seeks to address physical, mental and spiritual needs. St. Luke's Episcopal Health System has been instrumental in supporting the church's mission to care for the well-being of all Episcopalians, but also for all people in Puerto Rico. St. Luke's behavioral health professionals provide workshops and lectures to clergy that offer tools for their self-care as well as the care of members of their congregations. To date, this important initiative has helped hundreds of people who have been affected by different local challenges, such as the impact of hurricanes, earthquakes, pandemics, among others.

The Task Force is grateful to The Diocese of West Texas (DWTX) Commission on Mental Health and all the clergy and lay leaders seeking training from Sanctuary Mental Health here so that, in DWTX, everyone—those with often stigmatized mental health needs, those in recovery, those on the highways and in the hedges—has a place at the table.

The Bishop's Commission on Social Justice and Community Care in the Diocese of Los Angeles, which formed in 2020 after the public murder of George Floyd, has pressed for reforms that move toward a vision of "gospel-based policing." The Commission intentionally expanded its focus to encompass mental health and illness in relation to its work on criminal justice and needed medical and therapeutic treatment access during and following incarceration.

Seminary of the Southwest launched in 2017 what has become a successful program, the Master of Arts in Clinical Mental Health Counseling, integrating theological and spiritual perspectives with professional counseling.

Many earlier church leaders, both lay and ordained, contributed care and helped advocate care to those experiencing various forms of mental health challenges, including substance use disorder. The Rev. Shoemaker's Oxford Group meetings helped shape what later became A.A.'s Twelve Steps for Recovery. Organizations and networks like Saint Francis Ministries and Episcopal Community Services have been providing services for people with substance use disorder, mental illness, behavioral disorders, and family dysfunction.

The Task Force wishes to highlight the different places of ministry in the Episcopal Church that have begun to embrace MHFA training for its clergy and church members.

The Diocese of Georgia in 2023 devoted its clergy conference to MHFA training for all its clergy.

Province V dedicated a day of its April 2024 provincial gathering to MHFA training for church leaders from multiple dioceses and ministry settings.

Various congregations across the Episcopal Church are hosting trainings in MHFA. One example, All Saints in Richland, WA, used MHFA to help its clergy and lay leaders learn skills to interact with the people without housing who come to their new cold-weather shelter. Another example, a group of four congregations in the Yakima Valley, WA used MHFA to strengthen their skills for ministries that touch the lives of many lower-income people in their communities. These are only a few examples of how Mental Health First Aid is already being embraced across the Episcopal Church.

We wish to recognize work done by the previous Standing Commission on Health that existed for the Episcopal Church's health-related ministry and advocacy, from its inception through 2009.

We continue to extend full-hearted gratitude to the leaders of the National Alliance on Mental Illness (NAMI) and wish to affirm all Episcopalians who participate in NAMI support groups, community awareness-raising and educational initiatives, boards, and advocacy efforts.

We are grateful for colleagues on other Task Forces and Commissions of the Episcopal Church who are developing resources and partnerships for overlapping areas of suicide prevention, addiction and recovery, cognitive disabilities, neurodivergence, and trauma in Indigenous and LGBTQIA+ communities. We are also grateful for diocesan commissions and church-wide networks whose work on matters of community care, social justice, criminal justice and legal aid, homelessness and housing, and public health intersect with important issues related to mental health and mental illness.

There are many other faith organizations that have produced excellent resources and trainings, many of which our Task Force has used and referenced in our materials generated for the Episcopal Church. These include the following:

Liturgical and theological resources for mental health and illness from the Church of England

The WISE Congregations (Welcoming, Inclusive, Supportive, Encouraging) initiative of mental health ministry created by the United Church of Christ.

The Spiritual First Aid resource and training process created by Jamie Aten at Wheaton College's Humanitarian Disaster Institute.

The resources gathered from multiple sources at the website of the Interfaith Network on Mental Illness, including Carole Wills' "Mental Illness Resources Guide."

The Task Force wishes to mark the significant value of resources produced for faith-based organizations by the American Psychiatric Association and the U.S. Offices of Faith-Based and Neighborhood Partnerships, to assist faith leaders and communities in awareness of mental health and mental illness and in best practices for positive engagement with people. We commend these for use across the Episcopal Church:

Mental Health: A Guide for Faith Leaders,[1] American Psychiatric Association Foundation, 2018.

Compassion in Action: A Guide for Faith Communities Serving People Experiencing Mental Illness and Their Families, The Partnership Center, Center for Faith and Opportunity Initiatives[2], U.S. Department of Health and Human Services, July 2020.

The Task Force is particularly grateful for the emerging partnership with Mental Health First Aid as offered through the National Council for Mental Wellbeing. This foundational training for clergy and laity across the Episcopal Church will be easily joined with other important resources like Critical Incident Management Training (through the Crisis Prevention Institute), Spiritual First Aid (noted above), Crisis Intervention Team training (through C.I.T. International) and Psychological First Aid (a World Health Organization resource for post-disaster help), for a robust menu to develop skills and confidence in Church members.

[1] Mental Health: A Guide for Faith Leaders, https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental_Health_Guide_Tool_Kit_2018.pdf

[2] Compassion in Action: A Guide for Faith Communities Serving People Experiencing Mental Illness and Their Families https://www.hhs.gov/sites/default/files/compassion-in-action.pdf

Introduction to the Resolutions

The Task Force proposes seven resolutions to continue its work on strengthening the ministry of the Episcopal Church related to mental health and illness beyond the 2022-24 triennium. Below is a brief summary of these resolutions.

A073 A Standing Commission for Human Health and Wellness calls for the creation of a standing commission that focuses on all aspects of Human Health and Wellness which would continue much of the work that this Task Force has focused on.

A074 Completing Mental Health Ministry Curriculum for Clergy calls for the continuation and completion of all sections of the Mental Health Ministry Curriculum, provided herein, for the education and training of Episcopal clergy in regard to mental health.

A075 A Directive for Clergy Mental Health Ministry Training calls on the standing commission to work collaboratively in training clergy and postulants in the curriculum for Mental Health Ministry, aiming toward fulfillment of the Episcopal Church's expectation to train all its active ordained clergy, and to examine the potential for canonically requiring this training for all active clergy.

A076 Strengthening of Churchwide Training in Mental Health First Aid aims to expand the pool of MHFA instructor with training in Adult, Youth, and Teen certification instruction, to deploy the entire pool of instructors in the dioceses and ministry settings of their Provinces, and to fund their training and deployment.

A077 Additional Guidance for Inclusive and Metaphorical Language calls the Episcopal Church to include non-ableist and non-stigmatizing language in the liturgies and communications.

A078 Promote equity and to Reduce differences in Mental Health Outcomes encourages the church to advocate for people experiencing Mental Health challenges.

A079 Mental Health Sunday encourages the church to adopt the Sunday closest to October 10th as Mental Health Sunday and encourages the church to pray for people experiencing Mental Health Challenges.

Proposed Resolutions

A073 A Standing Commission for Human Health and Wellness

Resolved, That the 81st General Convention amend Canon I.1.2.n by adding a new subsection 6 thereto, to read as follows:

I.1.2.n

6. A Standing Commission on Human Health and Wellness. It shall be the duty of the Commission to

i. Develop and recommend policies, strategies, programs, and resources to the General Convention and the Episcopal Church that support and strengthen the church's ministry with all God's people as they seek to maintain and improve their physical, mental, spiritual, relational, and emotional health.

ii. Coordinate the development of resources to strengthen human flourishing and to support ministries of hope and healing of both physical and mental health.

iii. Facilitate the development of basic skills among all members of the church for care, support, inclusion, and advocacy for people wrestling with physical and mental health challenges.

iv. Develop and oversee training for all clergy and key lay leaders in mental health ministry.

v. Draw together the insights, best practices, and resources developed by varied Church bodies to address matters of human health and wellness, including work done on ministry in relation to substance use, suicide prevention, trauma and recovery, neurodivergence, developmental disability, challenges in aging, pain, and chronic illness, and to strengthen the response of faith communities in partnership with broad-based and local organizations.

vi. Expand resources and encourage practices of ministry that support mental and physical health, assist faith communities to establish habits and structures of welcome, inclusion, encouragement, empowerment, and advocacy for persons of all ages facing mental, physical, relational, emotional, and spiritual health challenges, and provide helpful aids for healthy living.

vii. Collaborate with other commissions, ecumenical partners, invested experts, and public agencies and organizations to create optimal resources and trainings.

viii. Collaborate in seeking of funding sources and grants, and in deployment of funds, that support training for clergy, lay leaders, and faith communities.

ix. Partner with other Church bodies in education and advocacy about social and economic conditions that either strengthen or harm human health and wellness, such as access to housing, healthy food, education, work with dignity, and health services, as well as freedom from violence, stigma, and racism.

x. Oversee the creation and content review of a sustained web presence that provides a gateway through links to robust resources for support and advocacy for human health and wellness.

xi. Direct curriculum on mental health ministry for clergy, postulants, and lay leaders, in consultation with the Standing Commission on Formation and Ministry Development and other Church partners as appropriate.

xii. Coordinate with networks and initiatives related to health and wellness both within and beyond the Episcopal Church, including but not limited to the Assembly of Episcopal Healthcare Chaplains, Allies for Recovery in the Episcopal Church, the Union of Black Episcopalians, the Episcopal Community Service in America, CREDO, St. Francis Ministries, the Interfaith Network on Mental Illness, NAMI's FaithNet, Lutheran Family Services, and varied faith-based wellness programs.

And be it further.

Resolved, That the General Convention request the Joint Standing Committee on Program, Budget, and Finance to allocate $75,000 to fund the work of the Standing Commission for the 2024-2027 triennium.

EXPLANATION

Over the past decades, the work of the Episcopal Church in ministry and advocacy regarding matters of human health and wellness has been steady but uneven, moving in tides of interest from triennium to triennium. Resolutions have been affirmed and Task Forces have been formed to conduct research, do work, and promote policies and programs for the Episcopal Church in regard to specific issues related to human health and wellness. Across the last 50 years, there have been fluctuating seasons of focus on aging, neurodivergent individuals and their families, substance use and addiction, suicide risk and prevention, reproductive health, maternal and infant health, palliative healthcare, childhood and adult disability, grief and bereavement, mental health, stress, and trauma. Much has been accomplished over the decades in affirming varied aspects of health and in seeking to address challenges to health and wellbeing. In each area of interest and effort, it has been challenging to sustain interest and maintain continued effort for the Episcopal Church. Different interim bodies have gone about good work and launched fresh proposals and program initiatives, but with rare interaction with each other about common or overlapping goals and plans. Additionally, Task Forces are short-term interim bodies; work that is partially or fully completed during one Task Force's life cycle may not be picked up or continued due to shifting interests of new triennial cycles, and some work may end up

repeated and reduplicated years later due to loss of continuity. Furthermore, there are areas of physical health that are largely untouched.

Two cases in point:

1) There have been fluctuating seasons of increasing and waning focus on mental health, with resolutions in 1991 and 2000 encouraging increased awareness of mental illness and support for those facing mental health challenges, and with a period of effort in creating an Episcopal Mental Illness Network (EMIN) as a web-based connective community. This network lost steam when it lost funding to support its continuing efforts, and its last website postings were in 2015. In the meantime, another resolution focused regarding families with children with neurodivergent challenges (ranging from attention deficit to autism) was brought forward and affirmed in 2012, but without clear interface with EMIN. A new Task Force on mental health was created in 2018 and renewed in 2022. At the same time in 2022, a wide array of other resolutions related to mental health (including substance use addiction and recovery, suicide risk and prevention, and trauma) resulted in the formation or continuation of other Task Forces, or referral of work to a Church Center staff office.

2) There was previously a Standing Commission on Health. This commission was last mentioned in 2009 and discontinued in the 2012 General Convention's move to eliminate most Standing Commissions. Since that time, some Standing Commissions have been reinstated or freshly launched. This movement toward a return of Standing Commissions has come as a result of recognizing the difficulty of developing continuity and sustained investment in churchwide initiatives when relying solely on task forces or on single Church Center officers.

These examples illustrate the weakness of largely resolution-driven approaches to developing steady and sturdy ministries that support human health and wellness. In order to build continuity and collaboration into such development for the sake of the whole Church in all its orders of ministry, a more enduring body is needed, in the form of a canonically confirmed Standing Commission.

The scope of this new commission will be to address matters of ministry in the forms of welcome, inclusion, support, encouragement, empowerment, and advocacy for people facing challenges in physical, mental, emotional, relational, or spiritual health; and to support churchwide efforts to strengthen health and wellbeing. Issues to address in the scope of human health and wellness will include a fuller array of mental health challenges and cognitive challenges including neurodivergence and developmental disabilities, personality disorders, substance use addiction, and the impacts of trauma, disaster, abuse, and moral injury. The scope will address physical health challenges including disease, enduring injury, disability or physical limitation, and cardiovascular, pulmonary, and gastrointestinal health. The realities of age-related changes over the course of human life and the unique challenges that can emerge at different points in life will help guide this commission toward best practices. Key focal points in all of the commission's work will be the importance of affirming the

dignity of all persons, the recognition of identity-related struggles that emerge with each health challenge faced, the need to combat cultural patterns of stigma and pigeon-holing, and the gifts of God in food, sleep and rest, and physical activity to sustain and strengthen human lives.

With such an enduring charge, this commission can work steadily on multiple fronts of ministry supporting human health and wellness, collaborating in development and sharing of resources across church bodies. Subcommittees working on specific issues will interact with one another and help refine each other's focal work in ways that lead to a more cohesive, holistic approach. With an enduring commission, it will be possible to encourage sustained learning and development of the Episcopal Church's capacity for ministry with people facing all sorts of health-related challenges. Training and resources can be developed and supported to strengthen capacities of lay members, deacons, priests, and bishops in nurturing wellness and being helpful companions in illness. An enduring commission will establish enduring collaborative relationships and partnerships with other effective organizations, agencies, and networks engaged in the work of human health and wellness. To build the strongest possible ministry capacities in the church for health, such partnerships will need to be with religious and secular organizations that represent the varied cultures within and between the nations served by the Episcopal Church.

Funding requested will support meetings for this new Standing Commission. Additional funding through other resolutions will support further training and deployment of Mental Health First Aid instructors that will include training for those working with youth, and creation of modules for the curriculum for clergy and lay leaders in mental health ministry and translation of the curriculum for Spanish-speaking communities.

A074 Completing Mental Health Ministry Curriculum for Clergy

Resolved, That the 81st Convention of the Episcopal Church direct the appropriate body to continue and complete the development of all sections of the Mental Health Ministry Curriculum for the education and training of Episcopal clergy in ministering to persons and families experiencing mental health challenges in the church; and be it further,

Resolved, That $20,000 be allocated for that work in this triennium; and be it further,

Resolved, That all curriculum modules be translated into all relevant languages in use by the Episcopal Church; and be it further,

Resolved, That $14,000 be allocated for that work in this triennium.

EXPLANATION

According to the National Alliance on Mental Illness, 1 in 5 U.S. adults experience mental illness each year, 1 in 20 U.S. adults experience serious mental illness each year, 1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year, 50% of all lifetime mental illness begins by age 14, and 75% by age 24. Suicide is the 2nd leading cause of death among people aged 10-14.[1]

Faith communities are on the leading edge of communities in interfacing with people experiencing a mental health challenge, including, but not limited to, mental health crises, mental illness diagnoses, and substance use disorders.

The Church can be a setting in which people experiencing a mental health challenge can feel that they will not be judged, or seen to be "weak" or stigmatized. In order meet the needs and respect the dignity of people experiencing, clergy and those seeking ordination need tools and training to deal confidently and pastorally with the issues that arise in the various setting in which they serve.

Recognizing this need, in 2022, the 80th General Convention passed resolution A109, which called for the creation of a curriculum to address mental health and that "all those to be ordained from January 2024 onward be trained" as well as recommending "the training of all active priests, deacons, and bishops in this curriculum for mental health and mental illness awareness."

The Task Force on Individuals with Mental Illness recognizes that, for many reasons including the short time frame between the 80th and 81st General Conventions, having training prepared for all active clergy as well as all those discerning a call to ordained ministry was a tall order. A draft of the curriculum was created and shared as part of the Task Force report. However, it is not ready for immediate implementation. The Task Force believes that this curriculum needs to be further refined and developed, with each section prepared for delivery in online and in-person formats. The curriculum in its complete form also must be translated and culturally adjusted for different ethnic and racial communities. The previous curriculum has been a joint effort between the Task Force on Individuals with Mental Illness and a sub-committee of the Standing Commission on Formation and Ministry Development, largely driven by the Task Force on Individuals with Mental Illness. This work is not strictly speaking a matter of formation but of equipping the saints with capacities and skills for a specific form of ministry in their faith communities and the public square. Moving forward, the Task Force recommends keeping this work with any bodies focused on Human Health and Wellness.

Completing a robust, centralized curriculum is an essential part of clergy education for mental health. It ensures that there is consistent and equitable learning across cultures and languages, establishes clear learning goals, and adapts to a changing world.

A075 A Directive for Clergy Mental Health Ministry Training

Resolved, That the 81st General Convention direct the President of the House of Deputies to assign to a church body the task of beginning training clergy and postulants in the curriculum for Mental Health Ministry as previously directed in 2022-A109, examining the potential for canonically requiring this training for all active clergy, and reporting to the 82nd Convention on the number of clergy trained and offering a proposal for implementation of training requirement.

EXPLANATION

According to the National Alliance on Mental Illness, 1 in 5 U.S. adults experience mental illness each year 1 in 20 U.S. adults experience serious mental illness each year 1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year 50% of all lifetime mental illness begins by age 14, and 75% by age 24 Suicide is the 2nd leading cause of death among people aged 10-14.[1]

Faith communities on the leading edge of communities in interfacing with people experiencing mental health challenges, including, but not limited to, mental health crises, mental illness diagnoses, and substance use disorders. Church can be a setting in which people experiencing mental health challenges can feel that they will not be judged or seen to be "weak" or stigmatized in various ways. In order meet the needs and respect the dignity of people experiencing, clergy and those seeking ordination need tools and training to deal with the issues that arise in the various setting in which they serve.

Recognizing this need, in 2022, the 80th General Convention passed resolution A109, which called for the creation of a curriculum to address mental health to be created and that "all those to be ordained from January 2024 onward be trained" as well as recommending "the training of all active priests, deacons, and bishops in this curriculum for mental health and mental illness awareness."

This resolution instructs the Standing Commission for Human Health and Wellness take steps toward fulfilling the goals set in resolution 2022-A109 by working with other church bodies in delivering the curriculum for Mental Health Ministry with postulants and ordained clergy. The new Commission will also consider the potential for codifying such training in the canons of the church alongside equivalent trainings on prevention of abuse and the church's teaching on racism. The Commission can bring a realistic timeframe for the training of active clergy in a curriculum that is in development, beginning with delivery of certification in basic Mental Health First Aid, an evidence- and research-based, peer-reviewed training, which the General Convention training provision called for in resolution 2022-A108.

Future canonical adjustment requiring all active clergy to be trained in a curriculum for mental health and wellness is crucial because it recognizes the significant role clergy play in providing support and guidance to individuals within their communities of faith and their wider ministry settings. Mental health training equips clergy with the knowledge and skills needed to offer effective pastoral care to those struggling with mental health issues, aid families of individuals facing mental health challenges,

attend more clearly to their own mental health, and foster strengths and skills in faith communities for welcoming, including supporting, strengthening, encouraging, empowering, and advocating with people facing mental health challenges. By reducing stigma, fostering early identification and intervention, and promoting a holistic approach to well-being, this holistic curriculum ensures that clergy can better meet the mental health needs of congregants. Moreover, by prioritizing the mental health and well-being of clergy themselves, this curriculum and training supports a healthier and more resilient clergy community.

[1] https://www.nami.org/mhstats, accessed 10/27/23.

A076 Strengthening of Churchwide Training in Mental Health First Aid

Resolved, That the 81st General Convention of the Episcopal Church authorize and fund the training of additional Mental Health First Aid (MHFA) instructors in the Episcopal Church to provide local, diocesan, and provincial trainings in both Adult, Youth, and Teen-2-Teen Mental Health First Aid, to expand the existing MHFA trainer pool and thus increase access to training for clergy and lay leaders across all Provinces of the Episcopal Church, with training to be completed by May 2027, so that they will become available as resource trainers for the dioceses in each Province; and be it further,

Resolved, That the 81st General Convention request that the Joint Standing Committee on Program, Budget and Finance allocate $102,000 from the Episcopal Church triennium budget appropriation for the funding of this work; and be it further,

Resolved, That the 81st General Convention recommend the exploration of MHFA International resources with the intent to expand MFHA training into non-English-speaking countries to provide trainer coverage as needed for all Provinces; and be it further,

Resolved, That the 81st General Convention authorize and fund the deployment of MHFA instructors, including basic travel-related support, across the next three trienniums to train all active priests and deacons by 2033 for an estimated cost of $159,000; and be it further,

Resolved, That the 81st General Convention request that the Joint Standing Committee on Program, Budget and Finance allocate $53,000 for that work in this triennium; and be it further,

Resolved, That $10,800 be allocated for the generation of printed instructional resources for the diocesan MHFA trainings.

EXPLANATION

Building on the work of the prior Task Force on Individuals with Mental Illness, we continued the focus on the provision of Mental Health First Aid (MHFA), which provides consistent training with resources that are easily adopted on a large scale. MHFA training helps people develop the skills to assist individuals experiencing mental health crises and link them to appropriate professionals and supportive networks. The training helps clergy and lay leaders to understand some of the experiences of those with mental illness and helps to destigmatize the realities living with of mental illness.

Recognizing the importance of training in MHFA, in 2022, the 80th General Convention passed resolution 2022-A108, which called for the authorization and funding for at least 15 regional trainers. The work of the Task Force on Individuals with Mental Illness in this most recent triennium resulted in the training of 11 Adult MHFA instructors covering 8 provinces. While this was an excellent move forward, additional trainers are required to provide more thorough provincial coverage, as well as to offer instruction in Youth and Teen-2-Teen MHFA.

This resolution calls for the training of additional Mental Health First Aid instructors in the Episcopal Church to provide local, diocesan, and provincial trainings in Adult, Youth, and Teen-2-Teen Mental Health First Aid, and for funding to support their training and provide basic travel-related support for all instructors' deployment.

The funding request for additional trainers will cover 14-16 instructors in each of Adult, Youth, and Teen-2-Teen MHFA, at a cost of $34,000 for each track (including travel) or $102,000 in total. This will yield a total of 53-59 instructors trained specifically for instruction in the Episcopal Church, to be joined by other Episcopal MHFA instructors already trained and active, who together will offer MHFA certification trainings across the church. Per year, their trainings will yield 2500-3500 Episcopalians certified in MHFA; per triennium, 7500-10,500 certified Episcopalians; and by the end of three trienniums, up to 31,500 certified Episcopalians.

The funding of travel-related expenses in deployment of MHFA instructors for active clergy and postulant training and other diocesan or ministry setting trainings will significantly reduce the cost per trainee for each certification course. The deployment of MHFA instructors over the next three trienniums includes roughly 213 trainings for the approximately 4,000 priests and 2,400 deacons, as well as all active bishops, comprising all active clergy by 2033. More trainings offered by instructors will equip lay members with the same fundamental knowledge and skills. The funding request for this deployment is $53,000 per triennium, or $159,000 in total.

Modest funding is also requested to support and reimburse instructors for production of supplementary printed materials to aid in the training being offered.

A077 Additional Guidance for Inclusive and Metaphorical Language

Resolved, That the 81st General Convention direct the Standing Commission on Liturgy and Music to include additional guidance in The Guidelines for Expansive and Inclusive Language regarding non-stigmatized language in the inclusive language section and non-ableist language in the metaphorical language section when drafting revisions and new liturgical materials; and be it further

Resolved, That when liturgical materials in languages other than English are developed for use in the Episcopal Church that they follow, to the greatest degree possible, the spirit and intent of these guidelines; and be it further

Resolved, That the 81st General Convention commend these guidelines to all persons who write or speak on behalf of the church for their serious reflection and consideration; and be it further

Resolved, That these guidelines be referred to Dioceses, Interim Bodies of General Convention, Executive Council and related bodies, Provinces, Church Publishing, and other organizations of the church for serious reflection and consideration when writing, speaking, or educating on behalf of the church.

EXPLANATION

Language is important for ensuring clear and concise communication of ideas. However, certain idioms and expressions have become hurtful for those in our communities. Stigmatized and ableist language prevent affected communities from growing beyond their stereotypical place in society.

Stigmatized language affects how individuals feel welcomed by a community. It can be regionally specific and culturally informed. As an international body, we need to make sure that we are respecting the dignity of all human being through words. Some words will be harder to give up and we will fight for favorite phrases that have long been divorced from their stigmatized origin. Thoughtful language is the first step in the invitation to the welcoming love of the church. We have seen this welcome in the symbols we adopt. It is now time to reflect on how language becomes a barrier to welcome, a barrier to reaching people in our communities. Most resources will highlight terms related to Mental Health and Substance Abuse.

Ableist language perpetuates a standard of a perfect human being. We know that only through God may we be made perfect. How that perfection is manifested on earth is not for our judgement. Ableist language abounds in our sayings and reflects the deeply imbedded use of metaphors in how our society describes and connects when communicating. Phrases like, ‘falling on deaf ears’, ‘the blind leading the blind’, ‘dumb’ and ‘lame’ all come from and perpetuate the societal ignorance of the perceived limitations of individuals with disabilities. Additionally, when discussing action, we must be intentional about how we refer to the action and what is being accomplished. To ‘go on a Walk’ puts an unintentional focus on

the action of walking, which can distance individuals that use alternative methods to move from one place to another. Replacing this language takes creativity to understand the invocation to participate.

Ableist and stigmatizing language can also overlap. Terms like 'crazy', 'spastic', and 'idiot(ic)' started as stigmatizing language to denigrate the populations living with mental, physical, and neurological health conditions. Continued usage transformed these into ableist language as people use them to distance and separate what is perceived perfect from the imperfect.

As we look through the liturgies of the church, the formation documentation, the prayers and spiritual resources, we should reflect on how small changes to how we refer to the saints, how we ask for intersessions and give thanksgiving to be inclusive to all (or to not be exclusive to some). As we refer to scripture, we need to make sure we do not perpetuate the sins of the past with unhealthy language around the message of the stories and lessons from the old and New Testament. The hope of this resolution is for the Standing Commission on Liturgy in partnership with other bodies, like Church Publishing (and the potential Standing Commission on Human Health and Wellness) to offer guidance through the language they propose to change.

Specifically, we want to make sure that:

- Under the Inclusive Language Section on Page 3, please add a sixth point in the list stating, "Stigmatizing language should be replaced with affirming statements and words that are more relatable and promote understanding."
    - You can help eliminate the misunderstanding and stigma that prevent people from speaking up and getting support by choosing words that are clearer and more neutral.

      Reference: https://www.nami.org/NAMI/media/NAMI-Media/Infographics/NAMI-Language-Matters.pdf (October 2023)
    - Stigmatizing language – such as "crazy" — perpetuates negative perceptions, which can result in people to be excluded from jobs, housing, social activities and relationships. Additionally, people may begin to believe the negative things that others say about them, delaying them on their recovery journey.

      https://www.mentalhealthfirstaid.org/2022/04/use-person-first-language-to-reduce-stigma/ (October 2023)
- Under the Metaphorical Language Section on Page 3, please add a second point. The second point should be, "Ableist language should be reviewed against the intent and action of the speaker and call. Ableism perpetuates a "normal" human experience to life that places artificial barriers around what is considered perfect. Language used should reflect the intent, not the action used to accomplish the intent. As an example, 'We shall go with Jesus', rather than 'We shall walk with Jesus.'

- Ableism is defined as discrimination or social prejudice against people with disabilities based on the belief that typical abilities are superior. It can manifest as an attitude, stereotype, or an outright offensive comment or behavior. When it comes to language, ableism often shows up as metaphors ("My boyfriend is emotionally crippled."), jokes ("That comedian was hysterical!"), and euphemisms ("He is differently abled.") in conversation.

  https://hbr.org/2020/12/why-you-need-to-stop-using-these-words-and-phrases (October 2023)

- Many people don't mean to be insulting, and a lot have good intentions, but even well-meant comments and actions can take a serious toll on their recipients.

  https://www.accessliving.org/newsroom/blog/ableism-101/#:~:text=Ableism%20is%20the%20discrimination%20of,defines%20people%20by%20their%20disability. (October 2023)

Concrete Examples of Stigmatizing Language as published by the National Institute of Health:

Instead of…	Use...
Addict	Person with substance use disorder1
User	Person with OUD or person with opioid addiction (when substance in use is opioids)
Substance or drug abuser	Person with Substance Use Disorder
Junkie	Person in active use; use the person's name, and then say, "is in active use."
Alcoholic	Person with alcohol use disorder
Drunk	Person who misuses alcohol/engages in unhealthy/hazardous alcohol use
Former addict	Person in recovery or long-term recovery
Reformed addict	Person who previously used drugs
Habit	Substance use disorder
	Drug addiction

Instead of…	Use…
Abuse	For illicit drugs: Use
	For prescription medications: Misuse Used other than prescribed
Clean	For toxicology screen results: Testing negative
	For non-toxicology purposes: Being in remission or recovery Abstinent from drugs Not drinking or taking drugs Not currently or actively using drugs
Dirty	For toxicology screen results: Testing positive
	For non-toxicology purposes: Person who uses drugs
Addicted baby	Baby born to mother who used drugs while pregnant
	Baby with signs of withdrawal from prenatal drug exposure
	Baby with neonatal opioid withdrawal/neonatal abstinence syndrome
	Newborn exposed to substances

https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction

A078 Promote Equity and to Reduce Differences in Mental Health Outcomes

Resolved, That the 81st General Convention of the Episcopal Church hereby encourage that Congress enact legislation on the following package of policies that would serve to promote equity and to reduce differences in mental health outcomes: address implicit bias and unconscious bias in mental health diagnostics and treatment; address data challenges; address Social Determinants of Health; and invest in mental healthcare professional diversity; better mental healthcare treatment available; and be it further

Resolved, That the 81st General Convention of the Episcopal Church urge Episcopalians to prayerfully consider how they can support individuals with mental illness and their caregivers; and be it further

Resolved, That the Episcopal Church call on all elected and appointed officials to advocate for policies to raise the quality and availability of mental health coverage for all people in states and local areas; and be it further

Resolved, That this Convention charges the dioceses and parishes of the Episcopal Church with advocating for those same policies in their communities and states; and be it further

Resolved, That this Convention transmit a message to each diocese of the Episcopal Church with a copy of this resolution before each Diocesan Convention following the 81st General Convention; and be it further

Resolved, That the Episcopal Church recognize that issues with mental illness, access to diagnosis and effective treatment, and lack of appropriate treatment for untreated or under-treated pain affect all communities, and there is a disproportionate effect on persons of color, persons with disabilities, and those affected by poverty; and be it further

Resolved, That congregations be urged to pray weekly during the Prayers of the People for those affected by mental illness and their families; and be it further

Resolved, That the individuals involved in undertaking this work remain cognizant of its relationship to other issues of serious concern to the Episcopal Church: gun violence prevention, substance use, suicide prevention, and trauma related to gender, sexual identity, or military service; and be it further

Resolved, That the 81st General Convention, consistent with established policies and procedures, refer this Resolution to the Office of Government Relations, so that it may take all actions necessary to accomplish the intentions and purposes of this resolution.

EXPLANATION

Mental Health is Health. The church can help to advocate for the policies that work, for the policies that are impactful, for the policies that will make a difference. Promoting legislation to advocate for policies addressing mental health coverage and access, as well as other critical issues, is of great importance to the Episcopal Church. Mental health is an essential aspect of overall well-being, and access to mental health services is crucial for individuals with mental illness.

By advocating for legislation that promotes mental health coverage and access, the Episcopal Church strives to ensure that individuals have the necessary resources and support to address their mental health needs.

Individuals with mental illness are more likely to experience trauma and violence. Other major topics of concern in the church such as gun violence prevention, substance use prevention and recovery, suicide prevention, and trauma related to gender, sexual identity, or military service intersect with and impact individuals with mental illness.

By promoting legislation to advocate for policies addressing these serious concerns, the Episcopal Church aims to create a more just, compassionate, and inclusive society, where individuals can access the necessary resources and support to address their various needs.

A079 Mental Health Sunday

Resolved, That the 81st General Convention of the Episcopal Church designate as Mental Health Awareness Sunday the Sunday closest to October 10th, which is World Mental Health Day; and be it further

Resolved, That the common objective is to raise awareness of the impact that stigma has on preventing open dialogue about mental health and mental illness with our families, our Church, and our communities; and be it further

Resolved, That the Episcopal Church encourage the education of its clergy and laity on how to support individuals with mental illness and their caregivers; and be it further

Resolved, That the 81st General Convention of the Episcopal Church send this resolution to each Diocese of the Episcopal Church to post a reminder through their primary communication channels to encourage participation in Mental Health Awareness Sunday; and be it further

Resolved, That we add our voices and prayers with those around the world seeking care and attention to treat mental illness.

EXPLANATION

Mental illness thrives in the darkness, the darkness of isolation, the darkness of ignorance, and the darkness of negative stigma. It is through public acknowledgement that we can bring relief, bring support, bring the light and love of Christ to all God's children. Just talking about mental illness can save a life. We hope that the church talks about Mental health and wellness throughout the year. The Episcopal Church is rooted in the tradition of corporate worship. If all faith communities in an area are focusing on Mental Health, it will magnify the impact in the world.

As for the date, October 10th, this is the globally recognized date for mental health awareness since 1992. We would like to recognize that In the United States of America, the entire month of May is designated Mental Health Awareness Month since 1949 and supported by various federal agencies. Additionally, the US honors National Minority Mental Health Awareness Month in July since 2008. There are many other national and global recognition dates that challenge the church's calendar for the number of celebrations. We have focused on the most inclusive of the celebration dates.

October is also an advantages time of year for reflecting on Children and Youth Mental Health as it is generally the start of the new school year. The inter-generational possibilities to discuss the stress of life will help to normalize conversations around the impact of stress and burn-out on Mental Wellness.

Once we have started to reduce the stigma to mental illness through these annual celebrations, we expect leaders to want to go deeper in how they can respond to the epidemic of mental illness. This is where resources and education are important. The Task Force on Individuals with Mental Illness has prepared a first set of resources which are shared as part of the 81st General Convention Bluebook. The Task Force is also recommending Mental Health First Aid as a preferred training for most faith communities. We commend other resources from the organizations and groups that are mentioned in the Bluebook Report Thanksgivings.

Lastly, we know that it can be simple to pass a resolution at General Convention, but much harder to implement. We hope by commending this resolution to communication offices of our various diocese, it will help remind our churches of the work done at convention. We understand that not all parishes or faith communities will be able to participate in Mental Health Awareness Sunday. But for those that are able, a gentle reminder can act as a launch pad for sharing ideas across networks. This also gives a chance for Diocesan level initiatives about mental health to have time in the spotlight.

As a church, it is only right that we close in a prayer. Prayer will not solve a medical issue, but it comforts and reminds us of the strength that God provides in times of difficulty.

Supplementary Materials

Instructors for Mental Health First Aid

As mentioned in the Mental Health First Aid Subcommittee report, below are the names of the first set of trainers that are available for provinces and dioceses to host Mental Health First Aid training per the guidance mentioned in the report. This list will be updated as new trainers are added. We know that there are other Episcopalians that are instructors in Mental Health First Aid in many of the dioceses, and we recommend adding them to your call sheet as well before circulating this list to parishes and other faith communities.

Certified Adult Mental Health First Aid Instructors

Province	Diocese	Name	Telephone	Email
I	Massachusetts	The Rev. Spencer Hatcher	240-527-7106	spencer@bchcenter.org
I	Western Masachusetts	Rev. Jason Burns	412-522-4456	deaconjburns@gmail.com
II & IX	Puerto Rico	Luis Collazo, MHSA	939-290-1065	luiscollazo70@yahoo.com
III	Pittsburg	The Rev. Carter Hawley	541-222-0933	chawley@episcopaldeacons.org
IV	Alabama	Linda Foster, Ph.D.	205-305-8085	drlindafoster@gmail.com
IV	Alabama	Cindy Wiley, Ed.S, LPC	205-774-2442	cindy@stmarysoth.org
IV	Atlanta	Tammy E. Pallot, M.S.	478-954-5441	tammy@stfrancismacon.org
IV	Atlanta	Rev. Jess W. Speaker, III	301-648-7584	jess@stcatherines.org
V	Eastern Michigan	McKenzie Bade-Knill	810-434-5982	mckenzie@campchickagami.org
VI	Iowa	The Rev Laurie Finn	520-981-4328	lauriefinn2@gmail.com
VIII	Olympia	The Rev. Jedediah Fox	425-408-2623	the.rev.jedediah.fox@gmail.com

VIII	Spokane	The Rev. David Gortner, Ph.D.	510-734-1066	dgortner@vts.edu

Mental Health Basics for the Episcopal Church

"Come to me, all you who are weary and are carrying heavy burdens, and I will give you rest. Take my yoke upon you, and learn from me, for I am gentle and humble in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light." (Matthew 11:28-30)

Mental Health and Mental Illness

Mental health is "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community." (WHO, 2023). In all stages of life, it profoundly impacts our thoughts, emotions, and behaviors, shaping how we handle stress, work and learn, interact with others, make decisions, and contribute to life in the world.

Throughout our lives, we may encounter challenges that affect our mental health, influencing our thinking process, mood, and actions. There are several contributing factors to mental health problems, including biological elements like genes or brain chemistry, life experiences such as trauma or abuse, as well as a family history of mental health issues.

Early Signs and Symptoms[3]	Continuing or Worsening signs and Symptoms	Crisis
Tired-looking Disheveled clothing Sadness Worry Difficulty concentrating or focusing on home, school or work Indecisiveness An emerging pattern of showing up late for or canceling personal and professional commitments	Withdrawing from family and friends Absenteeism or "presenteeism" Odd or erratic behavior Declining personal hygiene Hopelessness or despair Anger or rage Increasing self-blame or self-criticism Distorted body image	**May become a crisis:** Panic attack Aggressive behaviors Substance misuse Traumatic event Non-suicidal self-injury **Immediate crisis:** Suicidal thoughts and behaviors Medical emergency Severe alcohol or drug effects Severe psychotic states

Caring for individuals, families, and congregations addressing the mental health needs of the church becomes essential in creating vibrant, welcoming, Christ-centered relationships and communities. In this way, the Episcopal Church recognizes the need to meet individuals, families, and clergy where they are and provide sacred, supportive spaces to grow in love with God and one another. To address some of these issues, the Episcopal Church recognizes the need to support the mental health of our faith communities while bearing witness to the unique challenges of the time.

The stigma surrounding mental health continues to prevent many from coming forward and seeking mental health care. People are often ashamed to discuss their symptoms and may be reluctant to seek treatment and support because of concerns about what others will think. Studies show that with proper care and treatment, people with mental health challenges get better, and many recover completely.

Whether responding to mental health crises or managing ongoing, persistent mental health issues, we must prepare to meet the needs of our faith communities with compassion and grace.

Do these stories seem familiar in your faith community?

An active member has stopped coming to services regularly and often states reasons they cannot attend meetings of groups of which they are a part. They are difficult to connect with and are dropping other activities outside of church. When they are at church, they appear distracted, withdrawn, and irritable.

A previously explorative, curious, engaged, and outgoing child now appears uninterested and angry. The child no longer wants to participate in Sunday School or other activities, is resistant, and acts belligerently.

A senior citizen is now repeating discussions with you and does not remember details of recent discussions. They hesitate to participate in social functions with larger crowds or new people. They fight against any changes to their routines.

A youth has recently expressed having thoughts about taking their own life. They have recently been bullied in school and social media. They stopped going to youth group.

A well-known young adult shows up to church on Sunday morning but seems unaware of what is happening around them, is dressed inappropriately and/or is disheveled and unwashed and appears to have disorganized conversations and thoughts.

A youth no longer wants to eat dinners with the youth group and has changed their clothing style to baggy clothing that appears to hide their body. They no longer wear anything but long sleeves, no matter the weather.

[3] *Sources: NAMI.org, and Mental Health First Aid USA, 2020.*

Fast Facts

1 in 5 U.S. adults experience mental illness ***each*** year

2 in 5 U.S. adults experience mental illness in their lifespan

1 in 20 U.S. adults experience serious mental illness each year

1 in 6 U.S. youth aged 6-17 experience a mental health disorder each year

50% of all lifetime mental illness begins by age 14, and 75% by age 24

Suicide is the 2nd leading cause of death among people aged 10-14

People with serious mental illness die up to 20 years younger because of preventable physical disorders

A median of 11 years lapses between first mental health symptom and first treatment

National Institute of Mental Health, World Health Organization

&

NAMI.org

Jesus, looking at him, loved him. Mark 10:21

Best Practices:

1. Calmly approach a distressed person, ensuring you and they are in a safe, relatively private quiet space.
2. Ask open-ended questions. Actively listen to the response non-judgmentally.
3. Think of mental illness as a medical condition like cancer or diabetes. Prayer is very important but does not replace good medical care and therapy. Honor the person and respect as a complete human being, even with illness or disability.
4. Respect the experience of a person in distress as very real to them. Avoid platitudes like "cheer up," "make yourself happy," "you'll be fine," "just stay busy," and "stay positive."
5. Encourage medical and professional intervention when appropriate. Give options and empower the individual and family to find the best treatment and intervention for their time and place.
6. Be patient and allow plenty of time for the person to process information. You may need to repeat yourself.
7. Do not confront, criticize, blame, use sarcasm or patronizing statements, or try to argue someone out of what they are experiencing. Do not laugh or dismiss the person.
8. Look for ways a person typically seeks and finds help, such as taking deep, calming breaths, calling a friend, or going for a run – or non-traditional actions like fidgeting, rocking, listening to podcasts, watching cartoons, or coloring.
9. Follow up with someone you have been with during a time of mental distress. Let the person know it is okay to talk about what they experienced and how they are now – and it is okay to talk about anything else.

For I am convinced that neither death, nor life, nor angels, nor rulers, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation, will be able to separate us from the love of God in Christ Jesus our Lord. Romans 8:38-39

Mental health is significantly shaped by social factors:

Economic Stability,

Education Access & Quality,

Health Care Access & Quality,

Neighborhood & Environments,

Social & Community contexts which include race, culture, gender, age, disability, and sexuality.

Please keep these factors in mind. Each factor carries its own stigmas and non-addressing mental health. Care and intervention should be aligned with cultural sensitivities.

Mental Health Resources

In the case of an emergency, dial 911.

Organizations

Mental Health First Aid (MHFA)

Teaches how to identify, understand, and respond to signs of mental illnesses and substance use. The training teaches the skills needed to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis. The Episcopal Church has trained MHFA Instructors available to provide MHFA training. Contact Tammy Pallot at tammypallot@gmail.com to find an instructor near you.

National Alliance on Mental Illness (NAMI)

Provides resources, support groups, education, and training. (nami.org)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. (samhsa.gov)

Mental Health America

National nonprofit dedicated to the promotion of mental health, well-being, and illness prevention (mhanational.org)

National Institute of Mental Health

The National Institute of Mental Health (NIMH) is the lead federal agency for research on mental disorders. NIMH is one of the 27 Institutes and Centers that make up the National Institutes of Health (NIH), the largest biomedical research agency in the world. (nimh.nih.gov)

Crisis Lines

988 Suicide and Crisis Lifeline

Provides 24/7, free, and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals in the United States. Available in 240 languages. Call or text 9-8-8; chat online at 988lifeline.org/chat.

Veteran's Crisis Line

Dial 9-8-8 and press 1 at the prompt to be connected to the Veterans Crisis Line. Available in 240 languages. Call 9-8-8 then 1; text 838255, or chat online at www.veteranscrisisline.net/get-help-now/chat.

LGBTQI+ Crisis Line

Dial 9-8-8 and press 3 at the prompt to be connected to a counselor specifically trained in supporting LGBTQI+ callers. Available in 240 languages. Call or text 9-8-8, or chat online at 988lifeline.org/chat.

Disaster Distress Helpline

Call or text 1-800-985-5990. Provides immediate crisis counseling for people who are experiencing emotional distress related to any natural or human-caused disaster. The helpline is free, multilingual, confidential, and available 24 hours a day, 7 days a week.

Domestic Violence Hotline

24 hours a day, seven days a week, 365 days a year, the National Domestic Violence Hotline provides essential tools and support to help survivors of domestic violence so they can live their lives free of abuse.

Support Groups

	Meeting Information	Local Meeting Location	Local Meeting Dates/Times
Adult Children of Alcoholics & Dysfunctional Families	adultchildren.org		
Al-Anon and Alateen	al-anon.org		
Alcoholics Anonymous	aa.org		
Co-Dependents Anonymous	coda.org		
Dual Recovery Anonymous	draonline.org		
Gamblers Anonymous	gamblersanonymous.org		
Narcotics Anonymous	na.org		
Overeaters Anonymous	oa.org		
Sex Addicts Anonymous	sexaa.org		
Survivors of Incest Anonymous	siawso.org		
NAMI Family and Peer	Nami.org		

Local Medical Providers

Name		Address	Telephone
Primary Care Physician			
Therapist/Counselor			
Psychiatrist			
Psychologist			

Local Mental Health Facilities

Name	Address	Telephone
Crisis and Stabilization		
Domestic		

Law Enforcement

911 – Emergency Response, notify the operator you are calling about mental health crisis

Mental Health Law Enforcement – Local law enforcement agencies may have a specially trained response team to respond to mental health crises. For information, call your local police department's nonemergency number.

Contact/Department Name	Telephone

Church Support

	Name	Email	Telephone
Priest			
Deacon			
Pastoral Care Leader			

Family Members/Friends/Emergency Contacts

Please respect the wishes of the individual and family in maintaining the confidentiality of protected health information.

Name	Relation	Email	Telephone

Mental Health Ministry with Individuals in Crisis

What is a mental health crisis?

A mental health crisis refers to a state of acute distress or an emergency situation related to an individual's mental health. Behaviors that are unusual and potentially harmful for the individual or others signal a mental health crisis. People in mental health crises may appear overly emotional or emotionally flat. They may appear mentally altered, unable to communicate clearly or understand what is going on around them. Experiencing someone in a mental health crisis can be frightening for anyone, but it is important to stay calm, clear, and kind. A mental health crisis can happen in any place at any time. A few suggestions follow on how to respond when such events occur, including a spiritual reflection and resources of faith.

A Parable

There is a well-known young adult member of your ministry setting who shows up to church on Sunday morning who suddenly seems to be unaware of what is going on around them, is dressed inappropriately, displays poor hygiene, and appears to have disorganized conversations and thoughts.

Best Practices when a person having a mental health crisis comes to church:

Individual	Congregation/Clergy
Ensure the safety of all from risk of suicide or violence. Approach the person with a calm voice and express support and concern. If overdose is suspected and the person is unresponsive, call 911, turn the person on their side and administer Narcan. Have conversation in a private area. Ask how you can help. Be direct with questions about drug or alcohol use. Be patient and give them space and time to respond. Acknowledge the alarm someone is experiencing – and avoid expressing shock or embarrassment at hallucinations or delusions. Provide options and choices for next steps for help – do not give advice or make decisions for the person. Avoid touching the person unless you ask for permission. Be truthful and honest with the person in crisis about your actions. Do not make demands or threaten treatment or hospitalization	Be prepared to call emergency response (911) for injury, medical emergency, or general safety if needed – note in the call that it is a mental health crisis. Remain calm and provide personal space – do not crowd around the person, do not stare. Be prepared to provide water, food, or other needed comfort, as appropriate – or assist with contacting the person's social supports. If possible, move person to a quieter area or ask others to move to a different space. Continue connecting to a person recovering from a mental health crisis. Do not isolate or ignore the person. Have Crisis information readily available (easy access form provided in these files) Encourage people to use terms such as "person in a mental health crisis" or "someone is currently struggling with their mental health" and avoid stigmatizing language such as "crazy" or "insane." Have Narcan accessible in the church in the event of an overdose

Spiritual resources for people experiencing a mental health crisis

A Canticle or Psalm:

Lamentations 1:12,16; 3:19,22-24,26	*Psalm 69:1-3,13-17*
Is it nothing to you, all you who pass by? * Look and see if there is any sorrow like my sorrow, Which was brought upon me, * inflicted by God's fierce anger. For these things I weep; my eyes flow with tears, * for a comforter is far from me, one to revive my courage. Remember my affliction and my bitterness, * wormwood and gall! The steadfast love of God never ceases, * God's mercies never end. They are new every morning; * great is your faithfulness. "God is my portion," says my soul, * "therefore will I hope in God." It is good that we should wait quietly * for the coming of God's salvation.	1 Save me, O God, * for the waters have risen up to my neck. 2 I am sinking in deep mire, * and there is no firm ground for my feet. 3 I have come into deep waters, * and the torrent washes over me. 13 Those who sit at the gate murmur against me, * and the drunkards make songs about me. 14 But as for me, this is my prayer to you, * at the time you have set, O Lord: 15 "In your great mercy, O God, * answer me with your unfailing help. 16 Save me from the mire; do not let me sink; * let me be rescued from those who hate me and out of the deep waters. 17 Let not the torrent of waters wash over me, neither let the deep swallow me up; * do not let the Pit shut its mouth upon me.

A reading:

> ***The Lord waits to be gracious to you; therefore he will rise up to show mercy to you. For the Lord is a God of justice; blessed are all those who wait for him. – Isaiah 30:18***

A breath prayer:

Lord, help me. Lord, have mercy. Lord, guide me through this.
(Repeat each phrase with the person)

A Collect:

Lord Christ, you came into the world as one of us, and suffered as we do. As we go through the trials of life, help us to realize that you are with us at all times and in all things; that we have no secrets from you; and that your loving grace enfolds us for eternity. In the security of your embrace we pray. Amen.

Mental Health Ministry with Individuals with Persistent Mental Illness (PMI)

In the general population, there are many people whose mental health symptoms create lifelong challenges. Persistent mental health conditions such as major depression, bipolar disorder, post-traumatic stress disorder, anxiety disorders, substance misuse, and schizophrenia – as well as other diagnoses – present unique challenges in the congregational setting. Symptoms can fluctuate over time, and every person has a different set of symptoms. Illness and healing may not be linear.

It is important to continue contact with individuals experiencing ongoing, mental health symptoms, approaching them with compassion and patience. Long-term and recurring mental illness can be deeply frustrating, so it is important to remind individuals that management of symptoms and improvement in quality of life is possible. A few suggestions follow on how to engage helpfully with people with PMI, including a spiritual reflection and resources of faith.

A Parable

An active member has stopped coming to services regularly and often states reasons they cannot attend meetings or groups of which they are a part. They are difficult to connect with and are dropping other activities outside of church. When they are at church, they appear distracted, withdrawn, and irritable. This seems like the beginning of a cycle that the church has seen repeated in the past.

Best Practices for the care of individuals with PMI

Reach out to individuals who are struggling with their mental health or going through a "rough spot", offering support and compassion while listening rather than attempting "to fix."

Ask how someone is feeling, and if things are better or worse than yesterday and other days. Consider asking a direct question like, "Do you feel like you are functioning?"

Understand that individuals with PMI may think and act differently at times, but they also have unique perspectives and gifts to offer the church.

Watch for signs of (and consider asking about) risk for suicide or self-harm.

Encourage individuals to seek support from mental health professionals in their community and to follow recommended treatment.

Encourage individuals to connect with family, friends, or other people and groups for social support.

Seek ways to support families of individuals with PMI, perhaps providing meals, ride assistance, prayer shawls, or household help during a mental health emergency.

Encourage individuals to use resources they typically use to help support their mental wellness, including examining ways to help reduce stress like sports, listening to music, yoga, meditation, walking, cooking, or crafting.

Provide spiritual support and guidance by offering prayer, scripture reading, or the Litany of Healing to individuals and families to help augment professional mental health services.

Engage with educational opportunities and generate discussions around mental health in our congregations to help destigmatize mental health care to make it more accessible to all populations.

Spiritual resources for use for and with Individuals with Persistent Mental illness

A Psalm:

Psalm 46

1 God is our refuge and strength, *
a very present help in trouble.

2 Therefore we will not fear, though the earth be moved, *
and though the mountains be toppled into the depths of the sea;

3 Though its waters rage and foam, *
and though the mountains tremble at its tumult.

4 The LORD of hosts is with us; *
the God of Jacob is our stronghold.

5 There is a river whose streams make glad the city of God, *
the holy habitation of the Most High.

6 God is in the midst of her; she shall not be overthrown; *
God shall help her at the break of day.

7 The nations make much ado, and the kingdoms are shaken; *
God has spoken, and the earth shall melt away.

8 The LORD of hosts is with us; *
the God of Jacob is our stronghold.

9Come now and look upon the works of the LORD, *
what awesome things he has done on earth.

10 It is he who makes war to cease in all the world; *
he breaks the bow, and shatters the spear, and burns the shields with fire.

11 "Be still, then, and know that I am God; *
I will be exalted among the nations; I will be exalted in the earth."

12 The LORD of hosts is with us; *
the God of Jacob is our stronghold.

A reading:

Come to me, all who labor and are heavy-laden, and I will give you rest. Take my yoke upon you, and learn from me; for I am gentle and lowly in heart, and you will find rest for your souls. For my yoke is easy, and my burden is light. - Matthew 11:28-30

A breath prayer:

My soul clings to you; your right hand holds me fast – *Psalm 63:8*
(repeat prayer)

A Collect:

This is another day, O Lord. I know not what it will bring forth, but make me ready, Lord, for whatever it may be. If I am to stand up, help me to stand bravely. If I am to sit still, help me to sit quietly. If I am to lie low, help me to do it patiently. And if I am to do nothing, let me do it gallantly. Make these words more than words, and give me the Spirit of Jesus. *Amen.*

Mental Health Ministry with Family and Caregivers of People with Mental Illness

It can be too easy to overlook caregivers and family members of people with mental illness in crisis situations and in the enduring life challenges of persistent mental illness. But responses of ignoring, avoiding the topic, or assuming that everything is okay unless someone says something only perpetuate cultural habits of stigmatizing mental illness as a taboo subject and isolating caregivers and family members. People who care for and live with individuals with mental illness often bear significant burdens and experience cycles of deep worry, isolation, and loss of hope.

Like anyone else, family members and caregivers are God's beloved and part of the human family. They have good and bad days, wear old clothes or new clothes to church, and love or hate the coffee at coffee hour on Sundays. Christ calls us to care for, encourage, and support one another, including people working most directly and intimately with those with mental illness. What does it mean to provide Pastoral Care to a Family/Caregiver dealing with mental illness? A few suggestions follow on how to engage helpfully with family and caregivers, including a spiritual reflection and resources of faith.

A Parable

A family seems to be showing up on Sundays with a great weight on their shoulder. They are not sharing their stress with the faith community during coffee hour. One of their children, a teen in the youth group, has stopped regularly attending church. Finally, during Bible study, one of the parents mentioned that their teen, who had been bullied in school and online, recently attempted suicide and is currently under care for help dealing with depression and anxiety. As people listened compassionately, the parents shared that they feel overburdened, isolated, overwhelmed, and intensely worried about their child's future.

Best Practices:

General Parish Guidance:

Express empathy and compassion; minimize your own reflections.
Respect the challenge of their situation.
Remember support is not control; allow and honor people's decisions.
Be clear and honest; don't patronize, and don't stigmatize.

Providing Holistic Family Support:

Regularly check in with the family or caregiver to keep connected and best understand their needs.
Utilize compassionate listening; meet the family where they are in that moment.
Connect family members with the appropriate support group (age, demographic)
Offer meal support, ride assistance, prayer shawls, household help, or whatever may be needed.
Be prepared for ups and downs, highs and lows over time.
Encourage counseling as needed or desired, social connections, and activities that bring joy or relief.

Providing Support to Adult Family Member(s):

Help them reflect on and name what they need for self-care.
Provide your time to allow for them to rest and get away from the stress of the situation.
Help them realize that they are not to blame. Mental illness is a medical issue outside their control.

Providing Support to Sibling(s):

Help siblings maintain their normal routine or activities.
Provide time for kids to be kids.
Offer opportunities for kids to do something fun, engaging, and different, away from the home

Spiritual resources for use for and with Family and Caregivers

A Hymn or Psalm

Hymn 470 (alternate 469)		Psalm 139: 1, 2, 6-9
There's a wideness in God's mercy, Like the wide-ness of the sea; There's a kindness in His justice, Which is more than liberty.	There is plentiful redemption In the blood that has been shed; There is joy for all the members In the sorrows of the Head.	[1]LORD, you have searched me out and known me; * you know my sitting down and my rising up; you discern my thoughts from afar.
There is wel-come for the sinner, And more graces for the good; There is mercy with the Sav-ior; There is healing in His blood.	For the love of God is broad-er Than the measure of our mind; And the heart of the Eternal Is most wonderfully kind.	[2]You trace my journeys and my resting-places * and are acquainted with all my ways. [6]Where can I go then from your Spirit? * where can I flee from your presence?
There is no place where earth's sorrows Are more felt than up in Heaven; There is no place where earth's failings Have such kindly judgment given.	If our love were but more faithful, We should take Him at His word; And our lives would be thanksgiving In the goodness of our Lord	[7]If I climb up to heaven, you are there; * if I make the grave my bed, you are there also. [8]If I take the wings of the morning * and dwell in the uttermost parts of the sea, [9]Even there your hand will lead me * and your right hand hold me fast.

A reading: Glory to God whose power, working in us, can do infinitely more than we can ask or imagine: Glory to him from generation to generation in the Church, and in Christ Jesus for ever and ever. Amen. - Ephesians 3:20,21 or

For I am convinced that neither death, nor life, nor angels, nor rulers, nor things present, nor things to come, nor powers, nor height, nor depth, nor anything else in all creation will be able to separate us from the love of God in Christ Jesus our Lord. - Romans 8:38-39

A breath prayer or call and response:

I pray for Strength;	***God, I am sustained by your eternal love and presence***
I pray for Peace;	***God, I am sustained by your eternal love and presence***
I pray for Courage;	***God, I am sustained by your eternal love and presence***
I pray for Community;	***Jesus, I am sustained through remembrance of your suffering***
I pray for Rest;	***Jesus, I am sustained through remembrance of your suffering***
I pray for Endurance;	***Jesus, I am sustained through remembrance of your suffering***
I pray for Compassion;	***Holy Spirit, I am sustained by your prayer and comfort***
I pray for Joy;	***Holy Spirit, I am sustained by your prayer and comfort***
I pray for Wisdom;	***Holy Spirit, I am sustained by your prayer and comfort***
My soul clings to you;	***your right hand holds me fast***

A Collect:

O God, surround N. with your compassion as [they] live with N. in sickness. Help N. to accept the limits of what [they] can do, that feelings of helplessness and frustration [and anger] may be transformed into serene acceptance and joyful hope in you. Let [them] remember the grief and love of Jesus over the afflictions of his friends, knowing that God too weeps. Bring [them] gladness and strengthened love in [their] service; through Christ our companion. Amen.

Mental Health Ministry with Faith Communities Surrounding a Mental Health Crisis

Episodes of severe mental illness can happen at any time and any place. When these incidents occur in church, they can rattle people in our ministry settings. How are we called to respond?

While the disciples often initially responded to disability or disruptive behavior in unhelpful ways, Jesus was consistent in approaching or inviting the person in distress. It is a matter of how we approach situations, respecting the dignity of all people.

During and immediately after such events, we seek ways to help each other remain calm, focused, and appropriately responsive. Our first concern is for everyone's safety, quickly followed with intentional care for the person in distress. If emergency response is not necessary, we seek to help a person return to a level of calm, respectful of their space. Once the event has passed and the person has received appropriate care, members of the faith community need space to discuss and understand what happened, acknowledging anxiety but responding in faith. We want these events to be teaching moments to show God's Love in this world.

A Parable

On a regular Sunday, you are sitting in your regular pew listening to a regular sermon when an unfamiliar gentleman stands up and says, "I see King David flying on a star!!!"
The preacher stops the sermon momentarily while an usher goes over to the gentleman to do a wellness check of the individual. It is determined that the individual would like the usher to sit with them through the end of the service. After the service, the priest quietly talks with the gentleman while the congregation goes to coffee hour. People talked a bit about the experience during coffee hour.

The next Sunday, some are worried about going back to church for fear of the gentleman returning.

Best Practices: Teach, Practice, Model

During the Event:	During Fellowship after the Event:
Quickly assess if the person's mental health crisis poses danger to the person or other people (call 911 immediately if necessary) A couple of people, not everyone, engage the person using your De-Escalation Steps (remain calm, approach gently, speak calmly and directly with the person, listen without judgment, redirect) Others, resume activity and give space to those engaging the person; do not make the center of attention. Assess for immediate needs and appropriate response including emergency care, medical help, or family assistance	Have community leaders available to discuss feelings about the event. Do not act like the event did not happen. "Comfort each other" (1 Thessalonians 5:11), acknowledging your feelings but not gossiping about the person. Provide resources to help families debrief from the event during the week.
Next Few Weeks:	**Long-Term Response:**
Create an action plan if the individual returns, such as designating a pew partner or contacting the caregiver. Send a message to the congregation of general welcome, reminding the parish of the welcoming and inviting love of Jesus for all. Acknowledge fear and engage discussion. Create space for small group discussions around mental illness and the church's response. Youth and children's groups should have designated time to discuss the event in their language.	Train clergy and members in Mental Health First Aid Join or create a local affiliate of the National Alliance on Mental Illness Review your faith community's safety protocol; discuss mental health response regularly along with other crisis planning Become aware of local mental health crisis response resources with local EMTs/Police If needed, clarify and review boundaries with the individual who experienced a mental health crisis Find times during the year to include mental illness in sermons.

Spiritual resources for Faith Communities Surrounding a Mental Health Crisis

A Canticle:

Jonah 2:2-7,9

I called to you, O God, out of my distress, and you answered me; *
out of the belly of Sheol I cried, and you heard my voice.

You cast me into the deep, into the heart of the seas, *
and the flood surrounded me; all your waves and billows passed over me.

Then I said, "I am driven away from your sight; *
how shall I ever look again upon your holy temple?"

The waters closed in over me, the deep was round about me; *
weeds were wrapped around my head at the roots of the mountains.

I went down to the land beneath the earth, *
yet you brought up my life from the depths, O God.

As my life was ebbing away, I remembered you, O God, *
and my prayer came to you, into your holy temple.

With the voice of thanksgiving, I will sacrifice to you; *
what I have vowed I will pay, for deliverance belongs to the Lord!

A reading:

For this reason I remind you to rekindle the gift of God that is within you through the laying on of my hands, for God did not give us a spirit of cowardice but rather a spirit of power and of love and of self-discipline. - 2 Timothy 1:6-7

A breath prayer or call and response:

Give us Strength to move out of fear into love;	***Creator, Sustain us***
Give us Peace to move out of fear into love;	***Creator, Sustain us***
Give us Courage to move out of fear into love;	***Creator, Sustain us***
Give us Community to move out of fear into love;	***Son, Sustain us***
Give us Respite to move out of fear into love;	***Son, Sustain us***
Give us Endurance to move out of fear into love;	***Son, Sustain us***
Give us Compassion to move out of fear into love;	***Spirit, Sustain us***
Give us Joy to move out of fear into love;	***Spirit, Sustain us***
Give us Wisdom to move out of fear into love;	***Spirit, Sustain us***

Closing Hymn Lift Every Voice #72 Just a Closer Walk with Thee

I am weak but thou art strong;
Jesus, keep me from all wrong;
I'll be satisfied as long
As I walk, let me walk close to thee.

Refrain:
Just a closer walk with thee,
Grant it, Jesus, is my plea,
Daily walking close to thee,
Let it be, dear Lord, let it be.

[2]Through this world of toil and snares,
If I falter, Lord, who cares?
Who with me my burden shares?
None but thee, dear Lord, none but thee.
[Refrain]

[3]When my feeble life is o'er,
Time for me will be no more;
Guide me gently, safely o'er
To Thy kingdom shore, to thy shore. *(refrain)*

Outline for Curriculum to Educate and Train Episcopal Clergy in Ministry Related to Mental Health and Mental Illness

Task Force for Ministry with Individuals with Mental Illness

November 2023

Curriculum Modules and Core Content

"Truly I tell you, just as you did it to one of the least of these who are members of my family, you did it to me." (Matthew 25:40)

This document outlines the recommended content areas, learning aims, and capacity development goals for clergy and spiritual leaders in the Episcopal Church. In keeping with the charge given to the church in GC 2022's affirmed Resolution A109, "Developing Curriculum and Required Training for Clergy in Mental Health Pastoral Care," this curriculum outline significantly moves forward the call for "the creation and launch of new curriculum to train all Episcopal ordained clergy, candidates, and postulants in mental health and mental illness awareness that emphasizes pastoral care, the forming of caring relationships, and effective advocacy." There are ten core components in this curriculum. Each is explained and plotted in this document. Building upon foundations laid in Mental Health First Aid (MHFA) training, the curriculum expands and more deeply extends knowledge and training for clergy in mental health ministry with individuals, their families and caregivers, faith communities, and wider surrounding communities. The components, intended to be delivered in modular form for in-person, hybrid, and online completion, are as follows:

- Mental Health First Aid (MHFA) one-day training certification (foundational)
- Helpful and unhelpful theological/biblical frames and spiritual practices
- Individual pastoral and spiritual care, and discernment of concerns
- Family and caregiver pastoral and spiritual care, and discernment of concerns
- Community inclusion for individuals with mental illness and their families
- Care for community in balance with individuals' mental health/illness
- Self-recognition, self-review, self-restoration, self-resilience, self-strength
- Response to trauma in the wider community
- Establishing resource connections in one's community
- Alliance and advocacy

In total, the curriculum spans four to five days of learning and practice. Clergy and spiritual leaders completing the curriculum return with specific tools and practices, clear theological foundations, and charted goals and resource contact lists to guide development of faith communities' welcome, inclusion, accompaniment, support, encouragement, empowerment, and advocacy for people facing mental health challenges and their families.

Completion of instructional modules and learning tools, and Spanish translation and cultural adaptation, will be addressed early in the next triennium.

I. Mental Health First Aid (MHFA) training certification

The day-long basic training in Mental Health First Aid (MHFA) is the beginning foundation for clergy training in mental health and mental illness. MHFA is an early intervention education program that teaches individuals to recognize signs and symptoms of a potential mental health challenge, listen non-judgmentally, give reassurance, and refer a person to appropriate professional support and services. The MHFA instructor-led training consists of 10 learning segments. The in-person course may be taught in a single 7.5-hour session or broken into two sessions and delivered over two days. The blended MHFA consists of a 2-hour self-paced, 5.5 hours in-person or 6.5 hours virtual instructor-led training. Learners are taught an action plan that they apply for non-crisis and crisis situations. The skills obtained in MHFA are similar in scope to those obtained in Red Cross first-aid and CPR. The MHFA manual provides a more than sufficient foundation for clergy in evidence-based education about mental illness in general, and more specifically about anxiety, depression, substance misuse, psychoses and thought disorders, and eating disorders – and the best healthy ways to engage with people experiencing such distress.

Faith communities are often one of the first points of contact for people experiencing a mental health challenge. By obtaining the MHFA certification, clergy and congregation members can develop the knowledge and skills necessary to identify and provide initial support to those facing mental health challenges or struggling with their emotional well-being. They can effectively assess, respond to, and de-escalate critical situations, offering compassionate guidance and referrals to appropriate mental health professionals and other available support systems.

This certification empowers clergy members to create a safe, inclusive, and supportive environment where individuals can seek help without fear of stigma or judgment. These societal barriers can delay individuals from seeking the appropriate professional support they need. This empathetic approach helps break down the fear of being stigmatized or misunderstood, encouraging individuals to seek the necessary help and guidance.

MHFA one-day trainings are being offered by trained Episcopal MHFA instructors, who are available to offer the trainings at seminaries and diocesan schools, clergy conferences, and varied gatherings of clergy and lay-leaders in different settings.

II. Helpful and unhelpful theological / biblical frames and spiritual practices

Scripture, prayer, spiritual practices, and the theological beliefs and promises of Christian faith can be invaluable resources to people experiencing mental health challenges and crises, as well as for those who support them. These frameworks have and continue to provide important help – and they have been and continue to be used in some instances to do damage. They can help bring relief, comfort, and guidance for those wrestling with mental health challenges – and they can add fuel to the fire of problems in mental health.

Mental health is a part of God's gift to us in our creation, just like our physical health. This health is in a range of experience and expression, with bodies and minds widely diverse in capabilities and limits. The creation stories in Genesis paint a picture of a world in harmony and of humanity created to be complete with one another and not in isolation. But these stories give us no detailed descriptions of bodies or personalities. It is easy to impose on these stories of creation a vision of perfection. But these "perfect" images are our own creations and projections, arising from our sense of discrepancy between what we are and what we imagine is the ideal.

Nonetheless, creation's harmony was broken by sin. Perhaps the primal sin is the striving for perfection, for an ideal beyond our finite and individually distinct and quirky natures? Or was the primal sin instead the impulse to hide and deny what we are, and to descend into cover-up? Regardless, Christian theology consistently notes that sin is endemic to human life and is embedded in our relational and social patterns and structures as well as our thought patterns.

This recognition of sin can be over-conflated with the ways we face and contend with human suffering, fragility, and illness. Over the centuries, and preceding Christ, and in religions around the world, human wrongfulness (sin) has been tied closely to experiences of pain, disability, injury, and disease. Mental illness has been no stranger to this pattern, nor has addictive misuse of substances. There has been a pattern like we find in Jesus' disciples as they consider the man born blind: "Rabbi, who sinned, this man or his parents, that he was born blind?" (John 9:2). Jesus states clearly that neither is the case.

Mental illness, like physical illness, is not God's punishment, God's challenge for personal growth, or God's special attention to an individual.

There is much social damage and internal injury that people with mental illness and other mental health challenges have experienced in the Church, stemming from the perceived connection between sin and illness of all types. This connection has some root in scripture, e.g. Psalm 39:1, Genesis 3, or 1 Cor. 11. But there are ways that this connection has led to stigmatization of individuals, families, whole communities, and entire nations and races, thus contributing to the problems of internalized oppression and unaddressed intergenerational trauma. As followers of Jesus, we believe that there is sin and evil in the world, and that active rejection or distortion of God's will in the world in thought, word, and deed is real and has real consequences. There is

wide breadth of expression in human life available to us in the holiness of creation in its rich diversity—and there are boundaries.

At the same time, we remain rooted in a much fuller understanding of the nature of God, humanity, sin, and the ultimate goodness of creation. We continue to learn and see ways that some theological assumptions through the centuries have stigmatized and diminished different races, cultures, and classes of people as well as different layers of human experience, creating false associations with sin where there are none. Our most honest and rigorous theology in faithfulness to Christ Jesus will intently question and strive to correct any forms of stigma, minimization, or marginalization applied to human groups or types of human illness. Following the pattern of Christ Jesus the Healer, the One who is "God with us," we seek to meet all people where they are, de-stigmatize all forms of illness—and particularly mental illness—decouple the experience of illness from sin, and radically include all people within the Church as full and complete members and beloved children of God, as promised in baptism.

In our baptismal covenant, we promise to respect the dignity and worth of every human being. We must recognize that mental health is an integral part of the flourishing of each individual. The Episcopal Church acknowledges the importance of both spiritual and medical approaches in addressing mental health challenges. This means that individuals are encouraged to seek appropriate medical and therapeutic interventions alongside spiritual support and pastoral care.

The Church has long emphasized the principles of compassion, acceptance, and inclusion. In the area of mental health, this includes creating a supportive environment where individuals experiencing mental health challenges are welcomed into fellowship without judgment or stigma. Clergy and laity in faith communities together can provide support, care, and encouragement for those struggling with mental health challenges, encouraging and facilitating help in the forms of medical, therapeutic, social, and relational resources, and advocating for assistance and fair treatment when needed.

The Church encourages spiritual practices within our tradition, such as prayer, meditation, and participating in the sacraments, as aids to mental, emotional, physical, relational, and spiritual well-being for all people. These are rarely sufficient in themselves to bring "cure"; more aid and support are needed from medical and mental health professionals, social services, and wider communities of care.

Inclusion brings with it a readiness to be with people experiencing mental health challenges and mental distress. But inclusion and care of individuals coincides with care for the faith community as a whole. Matters of safety and health for the community set important boundaries on our behaviors, actions, and spoken words. Clarity in a faith community about such outer boundaries can help facilitate safety in which there is freedom for a full range of human expression. There are examples in Christian history of overly restrictive bounds in some communities of faith, and

other examples of overly (and perhaps naively) open communities of faith with no clearly stated bounds.

Achieving these aims will require the examination of our internal biases, both individually and systemically, in the area of illness and health, and particularly mental health and mental illness, much as we continue to confront racial, socioeconomic, and LGBTQI2S+ biases. The deconstruction of these biases requires us to unlearn what may have been long habits (such as use of phrases like "Isn't that crazy?") and to learn and practice new patterns (such as adjusting language to say, "Isn't that surprising?").

This curriculum aiming to achieve such reorientation delves into several areas.

Episcopal priests, deacons, and bishops will read, examine, discuss, and internalize theological frameworks that guide their pastoral encounters with people facing the challenges of anxiety, depression, substance misuse, psychosis, and internalized messages of self-harm. They will learn to distinguish helpful resources and perspectives from unhelpful ones, to inform engagement with different mental health challenges.

Framing the entire curriculum, and woven throughout all segments of the curriculum, this fundamental perspective is consistently emphasized and re-emphasized:

God loves us with an eternal love that is as impartial as it is everlasting. God is always present, nearer to ourselves than our next breath. As God is present to us, God relies on us to be present with one another. It is not God's will that people get sick physically or mentally. Mental illness is not an indictment of one's faith or inherent goodness. Mental illness is not some form of divine punishment. God is with us and knows our suffering and wrestling. We are not alone.

This perspective is not just demonstrated in words, prayer, or liturgy. This perspective is demonstrated through our actions with those in the headwinds of mental illness and mental health challenges. In the Beatitudes (Matthew 5) and in his great declaration in the synagogue as he read from Isaiah (Luke 4), Jesus embraces and calls us to embrace God's call to be with all experiencing any disability, oppression, or loss, to bring good news and point to paths of full life. As God is present, we are to be present. As God is merciful, we are to be merciful. The love of God is demonstrated through our presence – and how we are present – with people in need and distress.

A crucial part of learning mental health ministry is how to match spiritual resources and practices appropriately to different mental health challenges and mental illness situations in ways that strengthen health and redirect focus – and how to avoid inappropriate or mismatched spiritual practices and theological resources that end up contributing to symptoms or negative responses. As a guide, these research-based insights on the positive and negative impacts of spirituality on mental health (as summarized on WebMD) provide a starting framework for evaluating the match of spiritual practice to mental health challenges

(https://www.webmd.com/balance/how-spirituality-affects-mental-health):

Positive impacts of spirituality--

- A higher sense of peace, purpose, meaning, and hope.
- Improved confidence, self-esteem, and self-control.
- Making better sense of one's life experiences.
- When unwell, spirituality can held to find and feel inner strength, resulting in faster recovery.
- For a spiritual community: stronger support for the person, stronger confidence for the community.
- Efforts to improve and strengthen relationships with self and others.

Negative impacts of spirituality--

- Possibility of being taken advantage of, when emotionally vulnerable.
- When emotionally vulnerable, they are susceptible to being nudged into unhealthy activities.
- Potential to mix religious stories and teachings with delusional ideas about power or punishment.
- Potential to drift toward, or be lured toward magical thinking.

III. Key resources for this work include the following:

The Bible and Mental Health: Towards a Biblical Theology of Mental Health, edited by Christopher C H Cook and Isabelle Hamley, forward by Justin Welby, 2020 – a rich collection of helpful essays presented in a conference at Lambeth Palace in 2019.

Grace for the Afflicted: A Clinical and Biblical Perspective on Mental Illness, by Matthew S. Stanford, 2017 -- a careful biblical and scientific examination of mental health and mental illness by a scholar in the Evangelical world of Christian faith, as a corrective path for people who have been taught and have internalized theological perspectives that are negative and harmful.

Black Mental Health Matters: The Ultimate Guide for Mental Health Awareness in the Black Community, by Aaren Snyder, 2020

Theology vs Psychology: Understanding Mental Illness and Coping with its Presence in the Black American Church, by Frederick D. D. Woods and Jerrod Smith, 2020.

The Joy of the Disinherited: Essays on Trauma, Oppression, and Black Mental Health, by Kevin Dedner, narrated by Jeff "Giovanni" Flanigan, 2022 audio book.

Toward a Theology of Psychological Disorder, by Marcia Webb, forward by John Swinton, 2017.

Healing the Soul Wound: Trauma-Informed Counseling for Indigenous Communities, by Eduardo Duran, forward by Allen E. Ivey, narrated by Kaipo Schwab, 2019 audio book.

Mental Health Ministry Resources, by Carole J. Wills, 2010. Annotated bibliography of books, articles, and videos for use with faith communities. This document is offered through the courtesy of the Congregational Resource Guide: www.congregationalresources.org. https://inmi.us/wp-content/uploads/2017/04/congregational_resource_guide.pdf.

Spirituality and mental health, by Abraham Verghese, *Indian Journal of Psychiatry,* 2008 Oct-Dec; 50(4): 233–237. An Indian psychiatrist's perspectives on the need for continuing improvement in the field of psychiatry to address, make space for, honor, and treat as resource the religious and spiritual perspectives and practices of people with mental illness. The article provides worthwhile recommendations. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2755140/.

Religious Practices and Spiritual Well-Being of Schizophrenia: Muslim Perspective, by K. Irawati et al., *Psychology Research and Behavior Management*, March 2023(16), 739-748. Available in Creative Commons through Dove Medical Press. An important perspective on the value of spiritual practice for Indonesian adult Muslims with schizophrenia who are otherwise usually barred in Islam from community spiritual practices. https://www.dovepress.com/religious-practices-and-spiritual-well-being-of-schizophrenia-muslim-p-peer-reviewed-fulltext-article-PRBM.

Dictionary of Pastoral Care and Counseling, edited by Rodney Hunter et al., Abingdon Press, 1990/2005 -- this compendium provides insights into the art of pastoral care, support, and counseling as it relates to differing communities, life stages, and conditions of life and health.

Clergy as a frontline mental health service: a UK survey of medical practitioners and clergy, by William Heseltine-Carp and Matthew Hoskins, in *General Psychiatry, 33(6),* 2020 – in this study of clergy and mental health professional referrals in Wales, there are insights about the need for increasing clergy awareness and recognition of mental health challenges, as well as increasing adeptness of pastoral care and partnership-building by clergy so that referrals from mental health professionals to clergy might increase: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7590374/

IV. Individual pastoral and spiritual care, and discernment of concerns

Clergy encounter many people facing mental health challenges and wrestling with mental illness. Even in this age of increasing decline in religious affiliation, clergy remain an important first point of contact and counsel for people in distress. In the United States, 40% of people facing mental health challenges seek counsel, support, and direction from clergy, more than from psychologists

and psychiatrists.[4] In many other countries, this pattern is even more pronounced. It is a relief to know that the vast majority of clergy (80%-90%) refer people to mental health professionals, and are particularly good at referring people in crisis or experiencing psychosis. In this way, clergy are functioning well as gateways into mental health care rather than as gatekeepers. However, clergy are less certain about referral process for people with non-crisis but persistent mental health challenges such as depression and anxiety.

Mental health challenges manifest in different levels of intensity, and, accordingly, call for different levels of response. Intensity level is determined by assessing the level of impact on a person's life and on the person's family, household, and surrounding community. Mental health challenges can vary in intensity, ranging from acute situations that demand immediate intervention to ongoing conditions that require ongoing support and management. Additionally, newly emerging mental health concerns or shorter situational crises may require a tailored response. Thus, one first quickly assesses whether a person is in danger of suicide, self-harm, or harm to others. Then, at a broad level of assessment, one attempts to discern whether a person is experiencing a crisis, an ongoing condition, a new emergence, or a short-term situational response.

Different levels of response include intervention, accompaniment, support, integration, and growth. Regardless of level of response, it is important to communicate deep respect for the person's dignity and to offer an ongoing sense of appropriate autonomy and choice in the next steps taken. Interventions are typically necessary when dealing with mental health crises of high intensity. This involves promptly addressing the situation through immediate and targeted responses to secure safety and rapid assistance. This may include crisis hotlines, emergency services that are informed about mental health, or hospitalization if necessary. The emphasis during this level of response is on stabilization and prevention of further harm.

In situations where mental health concerns are ongoing, accompaniment is a crucial and primary response to support individuals with persistent mental health conditions. Accompaniment (along with readiness for intervention) are at the heart of the approach taught in Mental Health First Aid, and it involves approaching and being present with someone, listening in a way that acknowledges the intensity of their experience, providing support and helpful information without giving advice, nudging toward their seeking of support and help from professionals and family or friends, and helping them navigate the complexities of their mental health journey. Sustained accompaniment may involve regular check-ins, assisting in connecting with therapists and medical professionals, spending time together, or helping to connect with other social networks of people.

Support is a level of response that is invaluable regardless of the intensity of mental health challenge. A supportive environment where individuals feel safe and valued can foster healing and growth. This may involve encouraging support networks of loved ones, peers, or support groups that offer understanding, empathy, and guidance. Clergy can help shape the culture of faith communities in ways that foster support, which includes openness and normalization of conversations about mental and physical health challenges, involvement of people in everyday

and special activities, and conversing about typical life activities and events. Support can also encompass ongoing encouragement for people to "stick with it" in therapy, medication management, and other forms of professional help.

Integration is crucial to help people facing mental health challenges to turn, or return, to their normal life activities and patterns that helps sustain and strengthen them. This involves encouraging and assisting people in finding ways to live fulfilling and meaningful lives alongside their mental health challenges. Integration may include identifying strengths, building resilience, rebuilding daily routines, and finding strategies to manage symptoms effectively. This will include establishing or reestablishing patterns healthy eating, exercise, and sleep; working, volunteering, or otherwise offering skills and talents; finding activities that are emotionally and relationally nurturing; and engaging in spiritual practices.

Finally, growth can be seen as a long-term goal for individuals facing mental health challenges. Encouraging personal growth involves empowering individuals to understand and embrace their experiences, identify areas of growth, and take steps toward further self-development. In the context of a faith community, this can be an important part of normalizing and de-stigmatizing the experience of mental illness, since continuing growth is an invitation for all people of faith and is engaged and encouraged together in community. Growth is also part of the ongoing work of therapy, and is likely to be part of individual conversations and consultations with clergy and individual lay leaders. People may find significant growth through learning, training, fresh skill development, a rule of life, or entering into ministries of support, care, and advocacy for others.

This curriculum provides clergy and key lay leaders with further understanding of signs and symptoms of various forms of mental illness, along with some guidelines for most helpful forms of interaction with each. The curriculum draws upon resources regarding helpful responses and healing pathways for people encountering psychosis, dealing with patterns of substance misuse, seeking recovery from trauma, in enduring emotional turmoil, for facing other mental health challenges. These guidelines will help clergy avoid unintentionally simplistic, stigmatizing, or unsettling language that may occur if overlooking the complexity of mental health challenges.

Recognizing the interconnectedness of mind, body, and spirit, Episcopal clergy and spiritual leaders navigate between appropriate emphasis on spiritual matters through pastoral care and spiritual guidance and appropriate reminders about the value of medical and scientific resources for help from mental health professionals . This balance ensures a holistic approach that addresses both the spiritual and practical aspects of mental health care.

Collaboration with mental health care professionals is encouraged—but is done only when securing a person's consent for such conversation (or when threat of injury, harm, or suicide requires immediate attention regardless of choice). Obtaining a signed release prior to contacting a healthcare provider is strongly recommended. By working together, pastoral and spiritual care providers can support individuals in their journey towards mental wellness, ensuring a

comprehensive approach that acknowledges the importance of both faith and science in mental health care within the Episcopal Church.

"Spiritual First Aid" is a process akin to Mental Health First Aid that provides similar guidelines for ways of listening, accompanying, and responding to the types of challenges faced by someone in distress. This resource, developed by psychologist J.D. Aten as part of Wheaton College's Humanitarian Disaster Institute (2020), can be helpful as a foundation for pastoral care teams and faith community members in general. Building on a cycle of basic steps of presence – Attend, Ask, Act, and Repeat – "Spiritual First Aid" emphasizes accessing the following tools we have at our disposal.

- Active Listening: Full presence and space for non-judgmental listening, reflecting what you hear.
- Empathy and Validation: Show respectful recognition of someone's feelings and experiences. You do not need to (and should not) affirm the person's account of events and realities as factual, but it is important to acknowledge the pain, struggles, and difficulties of the experience.
- Prayer and Meditation: If appropriate and welcomed, offer to pray or engage in a moment of quiet contemplation and centering together for connection with God, inner peace, and renewed faith.
- Referrals: When the person's needs go beyond spiritual support or require professional help, encourage and offer appropriate referrals to mental health professionals, counselors, or other resources. If the situation is a crisis, you may need to make the calls, including emergency services.
- Scriptures and Sacred Texts: As appropriate, offer relevant scriptures or sacred texts that might gently suggest paths and open doors of recognition, comfort, inspiration, and guidance.
- Spiritual Counseling: This is not typically offered in a situation of crisis or worsening symptoms, and should only be used with caution with people experiencing delusions. After a person is calmer and re-centered, with the passage of some quiet time and space, it may be helpful to invite the person into a shared discussion of faith, purpose, and integration of spirituality with life.
- Encourage Community: Note the importance of community and involvement in gatherings with others (including the faith community). Encourage a person to connect with friends, family, or community members who will offer support, encouragement, and belonging.
- Self-Care: Remind the person of possible resources for self-care, asking what the person does to nurture health. Encourage individuals to engage in activities that nurture their mind, body, and soul, and to practice self-compassion during difficult times.

"Spiritual First Aid" uses the acronym BLESS to organize a framework for assessing and intervening, humbly helping, and providing practical presence. BLESS represents the first letter of each of the five core needs (Belonging, Livelihood, Emotional, Safety, and Spiritual needs) Spiritual First Aid addresses.

Belonging - Actively reach out to those isolated or disconnected, invite into community.

Livelihood - Check on employment and income that affect quality of life and meeting of needs.

Emotional - Cultivate a culture of support and openness so people can share emotions and seek aid.

Safety - Establish clear boundaries and expectations to ensure emotional and physical safety of all members, including clergy. Encourage open communication when addressing potential concerns.

Spiritual – Assist people facing challenges by fostering their faith and offering spiritual guidance.

Using the BLESS Approach to Assess and Address Unmet Core Needs

The 5 Core Needs	Assess Core Needs		Intervene to Address Primary Unmet Core Needs	
	Attend *(What to Observe)*	Ask *(What to Explore, Prioritize)*	Act *(What to Do)*	And Repeat *(if warranted)*
B = Belonging	Relationships	Social Questions	Provide Spiritual Support	*Address Secondary Unmet Core Needs*
L = Livelihood	Health and Finances	Resource Questions	Connect to Social & Healthcare Resources	*Address Secondary Unmet Core Needs*
E = Emotional	Mental Health	Well-Being Questions	Facilitate Lament	*Address Secondary Unmet Core Needs*
S = Safety	"Red Flags" (hints of experiencing violence, self-harm, or suicidal thoughts)	Threat and Harm Assessment Questions	Refer and Report	*Address Secondary Unmet Core Needs*
S = Spiritual	Meaning-Making and Religious Behaviors	Spiritual Struggles, Ultimate Questions (e.g., life and death)	Encourage Spiritual Coping	*Address Secondary Unmet Core Needs*

Drawn from Aten, J. D., Shannonhouse, L, Davis, D. E., Davis, E. B., Hook, J. N., Van Tongeren, D. R., Hwang, J., McElroy- Heltzel, S. E., Schruba, A., Annan, K., Mize., M.C. (2020). Spiritual first aid: A step-by-step disaster spiritual and emotional care manual (COVID-19 edition). Wheaton, IL: Humanitarian Disaster Institute.

Key resources for this section and the following section include the following:

The Skilled Pastor: Counseling as the Practice of Theology, by Charles Taylor, Fortress Press, 1991 – a solid foundation for basic pastoral care that draws upon key insights from cognitive-behavioral therapy and equips people to engage with intense emotions such as anger, guilt, fear, and sorrow.

The Guide to Pastoral Counseling and Care, by Gary Ahlskog and Harry Sands, Psychosocial Press, 2000 – two chapters from this book are particularly helpful in charting helpful interactions for clergy with people experiencing different types of mental health distress.

Trauma and Recovery, by Judith Herman, Basic Books, 1997 – foundational resource for trauma-informed understanding and pathways for healing.

The Body Remembers: The Psychophysicology of Trauma and Trauma Treatment, by Babette Rothschild, Norton & Company, 2000 – a sensitive approach to aiding people in the lengthy journey of recovery from trauma, with emphasis on small steps, respect of needed safe space, and holistic reading of cues.

A Resource Booklet for Mental Health and the Spirit, by the Union of Black Episcopalians Mental Health Task Force, July 2023, https://files.constantcontact.com/8a37aef2101/b03dcd12-22bd-4938-af47-2f869f66e017.pdf -- a very helpful resource for faith community members and leaders in recognizing and responding to emotional signs and symptoms related to mental health challenges, particularly naming realities of anxiety, depression, anger, grief and loss, and trauma in Black communities.

Mental Health: A Guide for Faith Leaders, by the American Psychiatric Association Foundation, 2018, https://www.psychiatry.org/File%20Library/Psychiatrists/Cultural-Competency/Mental_Health_Guide_Tool_Kit_2018.pdf – a useful introduction to mental health and illness, and a guide for faith leaders in including people with mental illness and supporting mental health treatment.

For Clergy: The Caring Clergy Project, found on the website of the Interfaith Network on Mental Illness, https://inmi.us/for-clergy/ -- this webpage provides a portal to instructional videos, tools, and resources for individual and congregational ministry with individuals with mental illness.

Compassion in Action: A Guide for Faith Communities Serving People Experiencing Mental Illness and Their Caregivers, by the Partnership Center: Center for Faith and Opportunity Initiatives, U.S. Department of Health and Human Services, July 2020, https://www.hhs.gov/sites/default/files/compassion-in-action.pdf -- a helpful guide compiled with people working with faith communities on best and most supportive responses to people with mental illness, providing a roadmap using seven compassion-in-

action principles that focus attention and perspective on inherent dignity, illness (not sin), caregiver, professional assistance, treatment and medication, complexity, and hope.

You Are Not Alone: The NAMI Guide to Navigating Mental Health, by Ken Duckworth and NAMI, 2022 – a direct aid for individuals and families discovering and maneuvering through the field of mental health services.

V. Family and caregiver pastoral and spiritual care, and discernment of concerns

In addition to care, support, referral, and advocacy for individuals facing mental health challenges, clergy and spiritual leaders in faith communities also provide pastoral and spiritual care to families and caregivers of people with mental health challenges. In addition to individual connections of support and care is the building of a faith community's capacity to provide connection, care, and accompaniment that assists families and caregivers.

Levels of concern and response. Levels of intensity of mental health crises or ongoing mental health challenges directly affect family, caregivers, and friends. A serious crisis, especially a first time, can overwhelm close contacts with anxiety, confusion, and fear, which can be followed by guilt, self-doubt, anger, grief, and other intense emotions. When living with, caring for, or assisting someone with persistent mental illness, there can be temptations to "go it alone" and be the source of all that the person needs; there are challenges of learning how to navigate the difference between helping and enabling, and how to find others as reliable supporters. When first facing an emerging mental health challenge in a loved one, a family member or caregiver faces challenges of not only their own disbelief but also the as-yet-unknown array of mental health services and support groups that one must discover and learn to navigate. Over the long haul, as with any caregiving, there can be weariness and exhaustion, accompanied by guilt and frustration for feeling depleted. There are cycles of hope and loss of hope, joy and anguish, relief and guarded watchfulness.

Just as with individuals experiencing different levels of intensity and duration in their own mental health challenges, there are different appropriate levels of response with family, caregivers, and friends. Crises and newly emerging mental illness may call for intervention to help family and caregivers find resources and develop new skills and habits, and to provide care and daily living assistance for family and caregivers while they put their energies into addressing the crisis at hand. As time unfolds, steady accompaniment provides family and caregivers with a sense of surrounding strength and care, and helps protect against their developing habits of "going it alone." Ongoing support comes in many forms including conversation, assistance with household care (such as mowing the lawn or shopping for groceries), introduction to support groups and to others who face the same challenges, and providing respite by stepping temporarily into the role of caregiving. The longer work of integration happens as family and caregivers adapt to a new pattern of life and begin to interweave a new reality into their life patterns and self-understanding. This is a space for important conversations, deep listening, pastoral care and guidance, and

receiving testimony of others who are further along this journey. Growth remains an important open pathway for family and caregivers, as they incorporate their experience and new learning into their identity, and as they seek and find spaces for their own lives to flourish—both with their loved one facing mental health challenges, and independent as themselves in ways that are distinct from their role. Clergy and faith community can provide such opportunities for growth, and have conversations that open the possibility.

The curriculum provides examples and invites stories that help strengthen clergy's and spiritual leaders' abilities in assessing and identifying signs and indicators that help them discern appropriate levels and forms of response. The curriculum also stresses the continuing importance of compassionate and non-judgmental presence with families and caregivers, with devoted practice of active listening and offering of encouragement and information without moving into advice or problem-solving. Tools and best practices help clergy and spiritual leaders strengthen their skills in choosing helpful responses, identifying specific needs and paths for assistance, acknowledging and openly discussing the realities and challenges being faced, offering information and resource connection that helps address stress and nurtures well-being, encouraging self-care practices, referring for their own mental and physical health care, assisting in building familiarity with resources for the person in their care, and introducing to networks in the faith community and wider community. Learning and practicing these skills also necessitates that clergy and spiritual leaders become familiar with community resources and networks, and encourages the building of a faith community's capacities for help, support, and advocacy.

VI. Community inclusion for individuals with mental illness and their families

Community inclusion for anyone is crucial for health. The "epidemic of loneliness and isolation" in America, as highlighted by the Surgeon General (2023), points to a problem that has been increasing over generations in modern life. Humans need connection, and mental and physical health are directly affected by isolation and loneliness. The curative power of connection is even more pronounced for those who have lived with the isolation that comes with stigmatization, marginalization, and other forms of exclusion from relationships and social networks. There is important work for faith communities in fostering, modeling, and promoting community inclusion and support for individuals and their families facing mental health challenges.

Deconstructing stigma is a first essential step. Stigma can emerge in all sorts of social and relational spaces, including public and civic groups, workplaces and schools, families, neighborhoods and marketplaces, faith communities, and within oneself. To address stigma and change stigmatizing patterns of behavior, speech, and thought, education becomes paramount. Workshops, presentations, and awareness campaigns are primary tools for educating a community about mental health and the challenges faced by individuals and families. MHFA training and NAMI (National Alliance on Mental Illness) programs are two primary resources. Personal stories shared by individuals, family members, and community colleagues humanize the

experience of mental illness, challenge misconceptions, and promote empathy and understanding. Faith communities that learn to deconstruct stigma and change their patterns in order to amplify respect of each person's dignity can become examples and instructional resources as they model, practice, and teach acceptance, compassion, and inclusion.

A second crucial step is addressing barriers to inclusion that may exist on interpersonal and structural levels. Interpersonal barriers can be addressed through education and training programs that include best practices for clergy, leaders, and community members. This helps people develop skills to approach, listen to, and support individuals with mental illness and their families. Additionally, facilitating open dialogue and providing opportunities for conversations about mental health will dispel fears, assumptions, and misunderstandings. Speaking openly about the topic of mental illness helps eliminate the irrational fear of "speaking the unspeakable."

Structural barriers, on the other hand, require proactive steps to ensure equal access and participation. Conducting accessibility audits can identify and address physical barriers that individuals may face in engaging with the community. Similarly, faith communities can assess their structures, communications, and built-in patterns for unintended barriers to people wrestling with mental health challenges. This often includes addressing the absence of language or recognition of mental illness as a human reality; as with individual modeling in speaking openly about the topic, it is invaluable for a faith community to make matters of mental and physical health and illness part of the patterns of communication. In the wider community, advocacy efforts work towards influencing local policies and practices to enhance inclusivity and support for individuals with mental illness.

As a faith community develops healthier, more positive patterns of inclusion of and interaction and communication with people with mental health challenges, the community also should equip itself with strategies for dealing with inappropriate behavior and for de-escalation with individuals experiencing a mental health crisis. In addition to tools and approaches provided through MHFA, other trainings and programs can be implemented to provide clergy, leaders, and community members with the necessary tools to handle challenging situations with empathy, patience, and understanding. Critical Incident Training, often available through local police or sheriff departments and public schools, can help a faith community develop response plans that help de-escalate volatile situations and set safe space.

In addition to these tools and practices for adults, the faith community benefits from attention to the specific needs of children and youth. Providing guidance and resources for parents and clergy to explain mental illness to children helps create an understanding and compassionate environment across all ages. Age-appropriate educational materials, workshops, and support groups can provide children with the knowledge and emotional support they need to recognize and navigate behaviors they may witness within the congregation.

In-church support groups for families promote community inclusion. By establishing specific support groups for families affected by mental illness, a safe space is created for sharing experiences, offering insights and guidance, and fostering mutual support. Educational sessions or guest speakers also provide valuable information, coping strategies, and resources to families within the congregation. A faith community may choose to create a covenant akin to the United Church of Christ's WISE Congregations initiative, to establish norms and practices to be a welcoming, inclusive, supportive, and empowering community for people with mental illness.

Beyond basic welcome are steps to include people with mental health challenges in the faith community's work, discipleship, service, worship, and leadership. This may include intentional recruiting and nomination of people with mental health challenges for varied roles that draw upon their gifts and strengths as well as provide an appropriate stretch and expansion of skills.

A faith community need not attempt to build all supportive spaces alone. Forging partnerships and connections with outside support groups such NAMI is vital. Collaborating with reputable organizations provides access to additional resources, training, and support for individuals and families. Opening church or school space to such organizations and networks for gatherings and volunteer initiatives can further anchor a faith community's commitment and continued learning. These connections help ensure appropriate referrals and access to specialized care when needed.

The curriculum guides clergy and spiritual leaders in implementing these various strategies so that faith communities can welcome and embrace individuals with mental illness and their families, promote community inclusion, provide support, and foster understanding.

Key resources for this section and the following section include the following:

Our Epidemic of Loneliness and Isolation: The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community, by Vivek Murthy, U.S. Surgeon General, 2023 – introduces research on social connection and its decline, and health consequences; outlines the benefits of socially connected communities and outlines strengths that emerge from social connection, offering recommendations to rebuild social connection.

Developing Welcoming, Inclusive, Supportive, and Engaged Congregations for Mental Health, resolution of the United Church of Christ (UCC) for WISE Congregations, 1995 – states the case for the UCC's churchwide focus on mental health ministry: http://www.moredomainsforless.com/wideningthewelcome/WISEcongregationsresolutionucc.pdf

A WISE Congregation for Mental Health, a sample congregational covenant voted and embraced by First Congregational Church of Boulder, Colorado, 2014 – setting specific goals and practices: https://drive.google.com/file/d/0BwnKh8CaRsKTNE9VYmxPVmlxSWM/view?resourcekey=0-inqiJr-ghhlsLJN8e9bWYQ

Living into a WISE Covenant:, in *Becoming a WISE Congregation for Mental Health,* United Church of Christ Mental Health Network, pp. 11-13, 2019 – pages 11-13 map out basic action steps for a local faith community: http://moredomainsforless.com/mhnucc/becomingaWISEcongregationformentalhealth2019ed.pdf

Ten Steps for Developing a Mental Health Ministry in Your Congregation, by Alan Johnson and the Interfaith Network on Mental Illness, 2017 – a solid checklist for what a local faith community can develop for mental health ministry: https://inmi.us/wp-content/uploads/2017/04/10_steps_handout_10-2013.pdf

Liturgical Sources for Mental Health and Well-Being, by The Church of England – worship services, thematic scripture readings, prayers, and responsories for use in faith communities: https://www.churchofengland.org/sites/default/files/2021-10/liturgical-resources-for-mental-health-wellbeing.pdf

Spiritual Support Group for Mental Health and Wellness Guidelines, by congregation members of First Congregational Church in Boulder, Colorado, 2012 -- sample meeting norms, expectations, and boundaries for a support group: https://inmi.us/wp-content/uploads/2017/04/Spiritual-Support-Group-Guidelines-2.pdf

Healthy Boundaries: Persisting in Sharing Christ's Love, by the Anabaptist Disabilities Network, 2018 – this website also contains helpful resources for congregations on setting healthy boundaries, post-traumatic stress disorder, suicide response, and mental health education: https://www.anabaptistdisabilitiesnetwork.org/Resources/Mental-Health/Healthy-Boundaries/Pages/default.aspx, https://www.anabaptistdisabilitiesnetwork.org/Resources/ADNotes/Pages/Setting-Healthy-Boundaries.aspx

Hospitality towards People with Mental Illness in the Church: a Cross-cultural Qualitative Study, by C. Lehmann et al. in *Pastoral Psychology, 71(1)*, pp. 1-27, 2022 – this article helps highlight the importance of hospitality as a cornerstone of welcome and inclusion of people with mental illness, and points to ethnic and cultural differences in understanding of how hospitality is exercised: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8554182/

Dealing with Destructive Behavior, in *Becoming a Safer Congregation: A UU Guide to Effective Safety Policies and Practices,* by Kim Sweeney and the Unitarian Universalist Association, 2018 – This excellent resource is contained within a manual that also addresses covenants of safety, security, active shooter protocols, and other matters of safety in ministry and on social media: https://www.uua.org/safe/handbook/covenant/dealing-disruptive-behavior

Education & Training Programs of the International Critical Incident Stress Foundation, Inc. -- this site provides access to enrollment in online learning programs for individual and group crisis intervention: https://icisf.org/education-training/

The Pursuit of Illness for Secondary Gain, by Ruth Davidhizar, in *Health Care Supervision, 13(1),* 1994 – this article raises the difficult topic of secondary gain, or positive advantages that emerge with or accompany primary symptoms of physical or mental illness.

An additional, more recent article online provides a helpful and compassionate consideration of secondary gain and how it functions to deal with secondary loss. Secondary Gains and Trauma Treatment, by Arielle Schwartz, at *Center for Resilience Informed Therapy*, August 2017: https://drarielleschwartz.com/secondary-gains-and-trauma-treatment-dr-arielle-schwartz/

VII. Care for community in balance with individuals' mental health/illness

Caring for the community in balance with individuals' mental health and illness is an important aspect of the life and health of the Church that requires attention and consideration. It involves establishing and maintaining clear boundaries, acknowledging and addressing mental health issues, distinguishing between primary signs and symptoms and patterns of "secondary gain," developing action plans and standard responses, and addressing and discussing the impact of any crises that may occur and affect the community directly.

Establishing and maintaining clear boundaries requires a balance between free range of expression and interaction on one hand and care for the safety and well-being of the community on the other hand. Boundaries are not meant to restrict, but are intended to create a space for healthy interactions that diminish anxiety and foster courage in openness and ease in being with one another. Such boundaries need not be over-restrictive, but set parameters for what is understood as not acceptable. Clearly communicated expectations and limits help individuals feel respected and valued as part of a community that shares a covenant of understanding. Clearly stated boundaries, mutually affirmed, help everyone self-regulate.

Creating a positive environment for both the community that includes individuals with mental health problems begins with acknowledging the reality of mental illness and mental health challenges, including behaviors and interactions that can create discomfort for others. Ignoring these impacts of mental health problems only allows unhelpful patterns to develop and frustrations and resentments to form, as patterns of behavior and interaction become the unacknowledged "elephant in the room." By acknowledging and openly discussing specific difficult behaviors and interactions with *any* individual, the community sets a pattern of accountability and concern with all its members, including but never exclusively singling out individuals with mental health challenges.

In relation to both critical incidents and other disruptive situations, there may be need for immediate response calling on a faith community's Critical Incident Training and developed plan for action. Rapid assessment calls for evaluation of how dangerous the incident or situation is. If not dangerous, the situation may still be disruptive, or it may be deeply offensive. These are helpful benchmarks for intervention.

In time, some members and leaders in faith communities can become more attuned to distinctions between primary signs and symptoms of mental health distress and patterns of what is known as "secondary gain." Primary signs and symptoms are direct expressions and experiences of a mental health condition. "Secondary gain" is a pattern of behavior that can emerge with some individuals who have a physical or mental illness or disability, who begin to seek advantages by exaggerating symptoms of presuming privilege and making demands on others because of illness or disability. It is a cautious matter to consider such distinctions, and yet there are situations in which people can "play the part" in order to solicit help and shift responsibility. If a question of possible "secondary gain" patterns arises, it is best to approach conversation about this in a spirit of curiosity and inquiry: "Is this something you can do for yourself and want to be able to do for yourself?" Distinguishing between primary and secondary issues helps supportive community members navigate the tension between assisting and enabling, and can help bolster the autonomy and self-direction of a person, even if that person may initially resent a refusal to do something for them when they can do and have done it for themselves or with some companioning assistance.

Minimizing the spread of the impact of certain behaviors is also crucial to maintaining balance. Some mental health issues, such as addiction or certain disorders, can have a ripple effect on the community. By implementing strategies to reduce the negative impact of these behaviors on others, the community can minimize the potential harm and promote overall well-being.

Developing action plans and standard responses is a proactive approach to caring for the community while also considering individuals' mental health and illness. By having predetermined strategies and procedures in place, the community can respond effectively and efficiently to various situations. This not only ensures the safety and support of individuals affected by mental health issues but also fosters a sense of unity and understanding within the community.

In conclusion, caring for the community in balance with individuals' mental health and illness requires a multifaceted approach that includes establishing boundaries, acknowledging and addressing mental health issues, distinguishing between primary symptoms and secondary patterns, minimizing the spread of impact, and developing action plans. By prioritizing mental health and providing support, communities can create an environment that promotes well-being and fosters a sense of belonging for all.

VIII. Self-recognition, self-review, self-restoration, self-resilience, self-strength

When it comes to mental health, it can be too easy for clergy and spiritual leaders to neglect their own well-being. But care for one's own mental health is essential in order to effectively support others. Care and management of one's own mental health involves ongoing self-recognition and self-review, times of self-restoration, resources for self-resilience, and building of self-strength.

Self-recognition is the ability to identify your own mental health needs, challenges, and patterns. This involves developing some basic habits of taking stock of oneself, not unlike stepping on the

scale or looking in the mirror daily, and akin to the Daily Examen of the Jesuits. In the rapid and pressured pace for clergy on the go and responding to multiple and competing pressures, this habit of practicing self-recognition can become easy to overlook.

Self-recognition and self-review may look like different things for different people, but some common signs of deteriorating mental health that deserve immediate attention include the following:

- Feeling overwhelmed, stressed, or anxious
- Having trouble sleeping or concentrating
- Feeling irritable or withdrawn
- Losing interest in usually enjoyable activities
- Having thoughts of self-harm or suicide

If any of these signs are manifesting, it is important to take action. Action begins with conversation with someone trusted: a friend, family member, therapist, physician, or fellow religious leader. It is especially important to reach out for professional help when one senses being "in over one's head" -- whether that overwhelmed experience is situational, work-induced, familial, or internal. At any time but especially in times of mental health distress, networks of support are invaluable. Such networks may include friends, family, colleagues, people experiencing similar challenges, neighbors, and mental health professionals. Clergy are not beyond the need for emotional support, practical assistance, and accountability.

Debriefing is the process of talking about and processing difficult experiences. This is a helpful for clergy and spiritual leaders anytime, as a preventative and self-care practice. It is especially important for processing intense experiences, traumatic events, and experiences of cumulative grief, moral injury, constant criticism, or negative self-assessment. Debriefing can be done one-on-one with a therapist, a fellow religious leader, or another trusted person, and can also be done in colleague groups or support groups.

Saying "No" can be difficult for clergy and spiritual leaders, who often feel a sense of obligation to help others. The practice of saying "No" is not only part of self-care, it is also part of helping others find and exercise their own autonomy and capacities. Saying "No" need not be confrontational or dismissive; it can be delivered in the form of saying "Not yet," "Not at this time," or "Not me." Setting this pattern early in a position of leadership is easier than re-setting patterns and expectations later. The following is a review list for clergy who likely know about these helpful solutions but may struggle to put them into practice:

1. Set personal boundaries.
2. Prioritize obligations: With multiple responsibilities and obligations, in order to avoid being overwhelmed or spreading themselves too thin, it is invaluable to prioritize commitments

and politely decline those that do not align with primary duties or would negatively impact core responsibilities.

3. Offer alternative solutions: Instead of outright refusing a request, clergy can suggest other individuals or resources that might be more suitable.
4. Explain limitations: Clergy acknowledge their humanity by explaining limits of time, resource, and expertise, and noting need for personal space or rest.
5. Maintain transparency: A "No" is received and understood when explained with transparency and respect.

Self-care is any activity that you do to take care of your physical, mental, and emotional health. Self-care is not about being selfish or lazy. It is about making your own needs a priority so that you can better serve others.

Examples of self-care include:

- Getting enough sleep
- Eating healthy foods
- Exercising regularly
- Spending time with loved ones
- Engaging in hobbies or activities that you enjoy
- Turning off work and taking breaks from work

The curriculum encourages clergy and spiritual leaders to take stock of themselves and their self-care practices, utilizing tools such as the Daily Examen, a time diary, and a listing of self-care practices. Some examples of how clergy members can practice self-recognition, self-review, self-restoration, self-resilience, and self-strength when dealing with mental health are as follows:

- Self-recognition—Keep a journal to track thoughts and feelings, to help identify patterns and triggers.
- Self-review—Take time each week to reflect on mental and emotional responses through the week.
- Self-restoration—Schedule regular breaks, commit to a day off, take a walk, spend time with loved ones.
- Self-resilience—Strengthen coping mechanisms for stress and difficult emotions. Exercise, meditate, pray.
- Self-strength—Build a strong network of support to help through normal and challenging times.

IX. Response to trauma in the wider community

No curriculum on mental health ministry would be complete without attention to the matter of trauma, particularly communal trauma. Response to trauma in the wider community involves crisis pastoral care, practical immediate and longer-term assistance, collaboration with others, ongoing care of stress response, and partnerships to address trauma-related issues, and restoration of community wellness, equity, and empowerment.

In the face of community trauma, pastoral response must be both immediate and ongoing. This requires informational contact with first responders and organizations in direct contact with areas affected, consultation and agreement on how to offer pastoral care and support, and awareness of the impact of trauma on individuals and groups in the community. In cooperation with other religious and secular care providers, clergy and spiritual leaders work with pastoral volunteers to provide immediate emotional and spiritual support to those affected, and develop strategies for ongoing pastoral care to address long-term healing and recovery.

Preceding and parallel with pastoral care is the provision of needed practical assistance. Community trauma may be linked to natural disasters, massive infrastructure problems, other significant accidents, or violence, each leaving structural, institutional, and physical damage in its wake. Relying once again on informational contact and consulting cooperatively with other organizations, clergy and faith community members work to assist in providing for practical needs arising from trauma. Immediate and continuing mobilization of resources and volunteers ensures a valued and sustained contribution to aid, relief, and recovery efforts. Faith communities and their clergy should not act in isolation. Practical aid is best delivered in collaboration and in concert.

It is rare that effective and full trauma response will be within the scope of any individual faith community, and it is a rarity for any faith community to take a principal leading role in trauma response. Humility and readiness to accept direction are important elements in a faith community's collaboration in response to trauma. Knowing the strengths and talents that the faith community can offer in the situation, clergy and other leaders can arrive with suggestions of how they can help in distinct ways. The strongest collaborative relationships and partnerships are often formed prior to crises – faith communities can initiate efforts to build partnerships with inter-church groups, non-governmental organizations (NGOs), government agencies, educational institutions, health programs, protective services, and neighborhood associations. Some of these partnerships will develop quickly in the midst of trauma response, but seeds of connection sown in prior days will facilitate more rapid coordinated response.

The capacity of a faith community's response to trauma in strengthened by its preparation and planning. This includes taking stock of available resources within the congregation, school, or organization that can be utilized during a trauma event; developing disaster preparedness plans

to efficiently respond to potential future incidents; and establishing relationships with community organizations in advance to strengthen the overall response system.

Initial response to community needs will likely lead to recognition of the need for additional learning and training. For instance, a parish in eastern Washington state saw a need to step into the gap in provision of cold weather shelter for people without homes. This was an important contribution to community services. As the team of volunteers engaged this work, they encountered mental health challenges and were not equipped for effective response. Between their first and second winters of offering this important ministry, they sought MHFA training to strengthen their mental health responses.

Responses to trauma have often not been equitable. Large-scale responses have left marginalized people with less power and resources than prior to the traumatic event. Episcopal faith communities with their clergy and spiritual leaders must keep their focus on promoting wellness, equity, and empowerment in trauma response efforts, with particular concern for communities at risk of being marginalized or neglected. Over the long term, faith communities help strengthen their wider communities and groups at risk by addressing systemic issues that contribute to vulnerabilities to trauma, working toward justice and equity in the community, and empowering people affected by trauma in their own processes of healing.

Trauma has enduring effects on individuals and communities, with impact that crosses generations. This curriculum equips clergy and spiritual leaders with resources to help faith communities understand long-term and generational trauma; the impacts of trauma on mental, emotional, physical, relational, and spiritual well-being; and cooperative approaches to break cycles of generational trauma and open paths of healing.

X. Establishing resource connections in one's community

This curriculum assists faith community members and leaders in establishing resource connections within their community, by identifying, leveraging, and developing working relationships with available mental health practitioners, support groups, and other resources. The following are steps that leaders complete in relation to their contexts of ministry:

A. Identify mental health practitioners within the faith community

- Invite faith community members who are mental health practitioners to identify themselves.

- Facilitate connections between these practitioners and ask them to offer their services and support in the faith community in ways similar to the model of parish nurses.

- Establish guidelines for appropriate referral and confidentiality practices.

B. Identify local public health, NAMI, and other social service and support resources

- Conduct a preliminary web search for community resources or access published regional lists.

- Ask members to expand and refine this list, and to include local public health offices and NAMI branches.

- Identify support groups, educational programs, and other resources offered by these organizations.

- Publish and distribute this list to members, post resources as appropriate on faith community websites, and promote awareness of mental health services available.

C. Expand Beyond Mental Health Providers

- Expand the list to include professionals and support resources in other areas of life where people may experience challenges, such as financial assistance, medical and dental aid, transportation, job assistance, and legal services.

D. Establish and strengthen community partnerships

- Recruit a team within the faith community to build relationships and partnerships with community organizations such as social service agencies, nonprofits, and educational institutions.

- Collaborate with these organizations on awareness-building events.

- Identify opportunities for joint initiatives, workshops, or outreach programs that address mental health needs in the community and expand access to resources.

E. Map clear referral processes and coordination of information

- Develop clear referral processes to connect individuals with mental health providers and support resources.

- Open procedures for appropriate release of information between clergy and professionals in mental health.

- Ensure confidentiality and privacy throughout the referral and coordination processes.

Examples of helpful resources posted for a diocese can be found with the Diocese of New Jersey (https://njmindspirit.org/) and the Diocese of Pennsylvania (https://www.ecsphilly.org/news-events/forum2023/).

XI. Alliance and advocacy

The curriculum concludes with this section aimed at equipping church members and leaders with the knowledge and skills to engage in alliance-building and advocacy efforts for the sake of promoting mental health and well-being, strengthening and improving mental healthcare services in all communities, and setting preventative measures and practices in place in society in order to reduce the incidence of mental illness.

A. Advocacy for individuals and families

Individual and familial advocacy is very direct alliance, assistance, and lending of influence and strength to help specific individuals and families face challenges, overcome roadblocks, and maneuver through mazes in healthcare systems, legal or financial systems, and other public or private support systems. Specific faith community members and leaders will have more skill in offering this kind of support, and others will be able to learn skills. A key part of such advocacy is willingness and readiness to be a voice and visible ally for those experiencing mental health challenges.

Faith communities can collaborate with networks such as NAMI to provide training on effective advocacy techniques in order to assist people in navigating mental health systems, accessing appropriate care, and advocating for their rights and needs.

B. Legislative advocacy for mental health care

At a regional, state, or nationwide level, advocacy involves raising awareness among legislators and policy makes about mental health needs in communities and pressing for improvement in mental health care. Clergy and spiritual leaders help shape such purposeful engagement among subsets of faith community members, assist in connecting them with allies and networks engaged in mental health advocacy, help them learn how to connect with current legislative initiatives on mental health, and encourage their training and learning of methods for engaging elected officials in written and more direct lobbying efforts.

C. Crisis response and alternatives

One specific topic to engage as advocates is around protective services' crisis response and engagement with mental illness. Forming watchdog groups and creative innovator groups to help police assess and improve their responses to mental health emergencies and to explore alternative crisis response methods and personnel are two examples of such advocacy. Such action may include advocating for the implementation and funding of crisis teams as a more appropriate and compassionate response to calls involving mental health crises. Clergy and spiritual leaders can help find learning opportunities for faith community members on crisis intervention techniques and ensure awareness of local resources for mental health emergencies.

D. Resources for alliance and advocacy

There are multiple organizations engaged in advocacy related to mental health, including the Episcopal Office of Government Relations and the Episcopal Public Policy Network, the American Psychological Association, and the National Alliance on Mental Illness (NAMI). Working with such organizations amplifies advocacy efforts in one's community, region, and state. This curriculum provides information on how to access these resources, and provides basic guidance for facilitating effective alliance-building and advocacy efforts with these organizations.

[4] Heseltine-Carp, W., & Hoskins, M. (2020). Clergy as a frontline mental health service: a UK survey of medical practitioners and clergy, *General Psychiatry, 33(6).*