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).*