B. We recommend that future publications of the denomination and its ministry units reflect the diversity of positions about problem pregnancies and abortion found herein. …

D. We recommend that the General Assembly acknowledge the prerogative of Presbyterian entities to participate in ecumenical and interfaith organizations that represent different points of view concerning abortion. We also urge the General Assembly Council and the presbyteries to affirm procedures by which particular churches may be assured that their mission funds will not be used in violation of conscience on this issue. (*Minutes*, 1992, Part I, pp. 373–74)

However, the only groups that receive funding or produce material or advocate on behalf of the PC(USA) are Presbyterians Affirming Reproductive Choice (PARO), the Washington Office, Women's Ministries, and the Advisory Committee on Social Witness Policy (ACSWP). All of these organizations produce material and advocate specifically and diligently *only* for the "pro-choice" position. The following examples are offered:

- The Washington Office has advocated to Congress on behalf of the PC (USA) in support of all abortions, including late-term abortions.

- The PC(USA) is a member of Religious Coalition of Reproductive Choice (RCRC). We support them with non-designated money. None of their literature or advocacies, including their 2006 late-term abortion statement, reflects the current 1992 abortion policy.

Thus not only do publications not reflect Position A found in the 1992 Policy (but only Position B), but in addition, the Washington Office, ACSWP, and Women's Ministries are funded with undesignated funds. This violates the call to see that churches be assured that their mission funds not be used in violation of their conscience on this issue:

Currently, there is no organization funded by the PC(USA) at the denomination level that advocates a pro-life position. This one-sided advocacy is not in compliance with our 1992 abortion policy, thus violating the 1992 policy's call for the ecumenical and interfaith organizations to "represent different points of view concerning abortion." While Presbyterian entities have joined and pay dues to RCRC, an entity that supports all abortions, no entity funded by the PC(USA) has joined or pays dues to the National Pro-Life Religious Council.

ACSWP ADVICE AND COUNSEL ON ITEM 10-04

Advice and Counsel on Item 10-04—From the Advisory Committee on Social Witness Policy (ACSWP).

The Advisory Committee on Social Witness Policy (ACSWP) advises that the recommendations of Item 10-04 be answered by the action taken on Item 10-03.

ACWC ADVICE AND COUNSEL ON ITEM 10-04

Advice and Counsel on Item 10-04—From the Advocacy Committee for Women's Concerns (ACWC).

Item 10-04 asks the 218th General Assembly (2008) to direct all PC(USA) entities to reflect balance and equality in both funding and publications when advocating both sides of the abortion issue. This action is requested in order to be in full compliance with the church's 1992 policy on abortion.

The Advocacy Committee for Women's Concerns (ACWC) advises this item be disapproved and refers to its comment on Item 10-03.

$Item 10-05

[The assembly approved Item 10-05 with amendment. See pp. 58, 59.]

Comfort My People: A Policy Statement on Serious Mental Illness

The Advisory Committee on Social Witness Policy (ACSWP) recommends that the 218th General Assembly (2008) of the Presbyterian Church (U.S.A.):

1. Commend the *Resolution on the Church and Serious Mental Illness* approved by the 200th General Assembly (1988) (*Minutes*, 1988, Part I, pp. 443–46).

2. Approve the following recommendations related to "Comfort My People: A Policy Statement on Serious Mental Illness":

a. Approve the policy statement and recommendations.

b. Receive the background sections and appendixes.

c. Approve the report as a whole for churchwide study and use.

d. Direct the Office of the General Assembly (OGA) to publish the entire report "Comfort My People: A Policy Statement on Serious Mental Illness" with appendixes and a related study/action guide; distribute it to the middle governing bodies and their resource centers, to sessions, and to libraries of the Presbyterian theological seminaries; and make additional copies available for sale to aid study and implementation efforts in the church.

e. Commend the members of the Task Force on Serious Mental Illness, the Synod Consultation on "Comfort My People: A Policy Statement on Serious Mental Illness," the staff of the Advisory Committee on Social Witness Policy (ACSWP), and the many individuals and groups who offered comments and suggestions in the development of this report on behalf of the whole church.

3. Approve the following definitions of (a) mental illness and (b) serious mental illness:

a. ***Mental Illness*** **is a medical disorder characterized by disturbance in thought, mood, or behavior that causes distress or impairment of spiritual, interpersonal, behavioral, and emotional functioning. If left untreated, all mental illnesses are impairing.**

b. ***Serious Mental Illnesses*** **are severe and persistent medical disorders characterized by impairment in mood or behavior that cause distress and/or impairment in spiritual, interpersonal, and behavioral functioning. Salient examples are the disorders known as schizophrenia, bi-polar disorder, and major depression. Characteristic symptoms of serious mental illness include hallucinations, delusions, disorganized thinking, extreme mood changes, overwhelming hopelessness and sadness, severely impaired perception, judgment, or insight, and problems with concentration and attention. Serious mental illness is an enduring condition that affects one's ability to cope with everyday challenges. If left untreated all mental illnesses may impair one's ability to establish and maintain interpersonal relationships, practice one's faith, worship God, attend school, go to work, or live independently. All mental illnesses can be impairing.**

4. Direct the Stated Clerk of the General Assembly to send a letter commending the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the American Association of Pastoral Counselors (AAPC), the American Hospital Association (AHA), the American Nurses Association (ANA), the American Psychiatric Association (APA), the American Psychological Association (APA), and the National Association of Social Workers (NASW) for including spiritual assessment and religious history when designing care plans fully informed by cultural awareness.

5. Direct the Stated Clerk of the General Assembly to send a letter encouraging the middle governing bodies, sessions, and individual members of the Presbyterian Church (U.S.A.), and its ecumenical partners to give prayerful attention to this policy statement as a help in responding to serious mental illness in their families, congregations, and in the communities where they live, minister, and work.

6. Urge the presbyteries to do the following:

a. Provide educational opportunities for members to learn about treatment, counseling, ministry with people with serious mental illnesses, and how to address the stigma of serious mental illness in their congregations, particularly in regard to the experiences of children and youth, women and men, the elderly, and racial ethnic groups.

b. Provide training for pastors, staff, and lay care providers to help them develop appropriate identification and intervention strategies for persons at risk for suicide, especially teenagers, young adults, and the elderly.

c. Provide continuing education for pastors, staff, and lay care providers to train them to recognize and intervene when a person with a serious mental illness also abuses drugs, including alcohol.

d. Provide continuing education opportunities for pastors to help them learn how to support and advocate for families in crisis and to make appropriate treatment referrals.

e. Require mandatory continuing education credits for pastors on issues of pastoral care such as serious mental illness, addiction, domestic violence, child abuse, and other pertinent health-care issues.

f. Encourage pastors to become aware of the quality of services provided at local treatment facilities by consulting with administrators and care providers of those facilities, touring those facilities, and talking with people who receive such services.

g. Encourage pastors to preach sermons and provide Bible studies about serious mental illness.

h. Support the ministry and witness of the Presbyterian Serious Mental Illness Network (PSMIN), Presbyterians for Addiction and Action (PAA), and the Presbyterian Association of Specialized Pastoral Ministries (PASPM) of the Presbyterian Health, Education, and Welfare Association (PHEWA), and Pathways to Promise, and encourage pastors and local sessions to do the same.

i. Encourage pastors to learn about the resources of the Veterans Administration (VA), as well as educating them to the needs of veterans of all ages, genders, and ethnicity.

7. Urge committees on preparation for ministry (CPMs), in consultation with the Office of Vocation of the General Assembly Council (GAC) and the Office of the General Assembly (OGA), to do the following:

a. Educate themselves about serious mental illness in order to help discern the call of individuals under care with understanding and compassion. This discernment should include consideration as to whether this person can be effective in the ministry of Word and Sacrament.

b. Assist individuals under care to find resources and support for any serious mental health concerns.

c. [~~If an inquirer or candidate does not pass ordination exams, explore alternative means for administering ordination exams among the range of tools for assessing readiness for ministry.~~] [Explore alternative means for administering ordination exams among the range of tools for assessing readiness for ministry, if an inquirer or candidate does not pass ordination exams.]

d. Encourage uniform standards and a uniform process for the psychological evaluation of candidates for ministry.

e. Require candidates for ministry and commissioned lay pastors (CLPs) to have successfully completed at least one unit of accredited clinical pastoral education (CPE).

8. Encourage committees on ministry (COMs) to do the following:

a. Educate themselves for early identification of pastors who may have a serious mental illness.

b. Develop more effective early intervention strategies and follow-up in dealing with pastors, sessions, and congregations when serious mental illness may be involved.

9. Urge sessions and congregations to do the following:

a. Prominently display educational material regarding serious mental illness, such as location and times for local meeting of the National Alliance on Mental Illness (NAMI)— support groups/family-to-family training).

b. Display pamphlets from national advocacy groups such as Pathways to Promise, Substance Abuse and Mental Health Services Administration (SAMHSA), Presbyterian Health, Education and Welfare Association (PHEWA), and the National Alliance on Mental Illness (NAMI).

c. Subscribe to newsletters or web-based information updates from agencies listed above and post in newsletter/bulletin boards.

d. Provide support and advocate for individuals and families affected by serious mental illness.

e. Provide meeting room space for support groups and guidance for prayer-based support programs.

f. Consider forming a relationship with a local chapter of the National Alliance on Mental Illness (NAMI) for the purpose of fostering relationships between members of the congregations, their families, and people with serious mental illness.

g. Advocate for establishment of funding of not-for-profit agencies, counseling centers, and treatment programs for persons who struggle with mental illness, including those with dual diagnoses of alcohol and drug abuse.

h. Work to end the stigma of serious mental illness within the congregation and in the surrounding community.

i. Invite local mental health professionals to address serious mental illness in small groups and in worship services, and encourage family members with serious mental illness to attend them.

j. Create a church environment open to the transforming work of God where people know confidences will be kept and they will be accepted and supported when they ask for help.

k. In under-served areas, advocate for greater availability of mental health resources.

l. Encourage all members to prepare a Psychiatric Advance Directive (PAD), which specifies plans for their treatment in case of a mental health emergency. (Refer to Appendix D for an example of a PAD.)

m. Gain a deeper awareness of our own perceptions and attitudes regarding mental illness by making use of the recommendations here as well as the information provided in the background or rationale section of this report.

n. Encourage greater awareness regarding race, ethnicity, gender, class, age, and language as these relate to persons with a serious mental illness.

o. Advocate for housing for people living with a serious mental illness.

p. Encourage local sessions to adopt specific psychiatric units for prayer support, visits (when permitted), and material donations.

q. Conduct acts of worship recognizing Serious Mental Illness Awareness when designated in the *Presbyterian Planning Calendar*, Mental Health Awareness Month (May), and Serious Mental Illness Awareness Week (the first week in October).

r. Support the ministry and witness of the Presbyterian Serious Mental Illness Network (PSMIN), Presbyterians for Addiction and Action (PAA), and the Presbyterian Association of Specialized Pastoral Ministries (PASPM) of the Presbyterian Health, Education, and Welfare Association (PHEWA), and Pathways to Promise, and encourage pastors and local sessions to do the same.

s. Encourage local hospitals to design comprehensive discharge plans for all psychiatric patients and to collaborate in and monitor the full implementation of these plans with available social service agencies post discharge.

t. Support church-based counseling services staffed by mental health professionals.

u. Support and advocate for resources to assist veterans such as: the Veterans of Foreign Wars (VFW), Disabled American Veterans (DAV), and The American Legion.

v. Inform and encourage veterans within the congregation to seek available resources to help them such as: the Veterans of Foreign Wars (VFW), Disabled American Veterans (DAV), and The American Legion.

w. Become active in helping members of the congregation prepare a Wellness Recovery Action Plan (WRAP).

10. Encourage the Presbyterian Health, Education, and Welfare Association (PHEWA) to establish a churchwide web-based network of congregations who are engaged in ministries with persons and families affected by serious mental illness.

11. Direct the Presbyterian Washington Office (PWO) do the following:

a. Advocate for federal legislation that would increase and improve availability of mental health services in under-served areas.

b. Advocate for federal legislation that would increase and improve care for vulnerable, high-need groups in racial and ethnic populations. Such legislation should include an increase in the number of multilingual and minority mental health practitioners.

c. Advocate for federal legislation aimed at reducing the alarmingly high rate of suicides among elderly people. In addition to traditional psychological and medical interventions/treatments, efforts should be directed to reducing many of the social problems of the elderly, such as isolation and poverty that exacerbate mental illness.

d. Advocate for federal legislation that would create health maintenance systems for persons with a serious mental illness to reduce symptom relapse and suicide risk.

e. Advocate for federal legislation that requires parity in the coverage of mental health care and general health care, so that mental illnesses are covered on the same terms as other illnesses.

f. Advocate for federal legislation that would increase and improve the Veterans Administration (VA)'s ability to care for veterans with mental illness.

12. Direct the Presbyterian United Nations Office (PUNO) to do the following:

a. Advocate for international human rights treaties that would protect the rights of persons with a mental illness.

b. Advocate for international human rights treaties that would improve mental health care universally.

13. Urge the Board of Pensions (BOP) to maintain its practice of providing benefits parity for treatment of mental illness.

14. Urge Presbyterian theological institutions and those related to the Presbyterian Church (U.S.A.) by covenant agreement to do the following:

a. Instruct students about the spiritual and social dimensions of mental health, and equip them to recognize the signs of mental illness and inform them of available treatments.

b. Instruct students about the most recent medical research and findings regarding the causes of mental and serious mental illnesses.

c. Instruct students on how to listen to, pray for, and follow-up with people who have a serious mental illness crisis and their families, including how to make appropriate referrals.

d. Encourage those who are training to be worship leaders to use sermons and stories to educate their congregations about mental health and mental illness, and also to plan worship that celebrates occasions for mental health awareness.

e. Provide educational opportunities about public advocacy issues affecting people with serious mental illness.

15. Direct the Stated Clerk of the General Assembly, stated clerks of the middle governing bodies, stated clerks of the local sessions, and individual Presbyterians to:

a. Urge local police to be trained to respond justly and humanely to persons with serious mental illness.

b. Urge the department of corrections to recognize and respond appropriately to the needs of inmates with serious mental illness and provide timely, accessible, and high-quality treatment for incarcerated persons with serious mental illness.

c. Support treatment and care facilities as alternatives to incarceration for persons with serious mental illness.

d. Urge careful planning for the release of prisoners so they receive immediate and intensive short-term support.

e. Encourage the criminal justice system to incorporate an evaluation for serious mental illness in sentencing and release guidelines.

f. Urge continuing education requirements and training programs for legal professionals, so they can keep well-informed about treatments for persons affected by serious mental illness.

[16. Direct General Assembly Council to provide certified chaplains and/or pastoral counselors in collaboration with the Presbyterian Association of Specialized Pastoral Ministries (PASPM) at large Presbyterian gatherings such as the Peacemaking Conference, the Youth Triennium, the triennial gathering of Presbyterian Women and the biennial meeting of the General Assembly.]

[Financial Implications: (2006): $0; (2009): $10,800; (2010): $10,800 (Mission)]

Rationale

This report with recommendations is in response to the following referral*: 1999 Referral: 25.039 Response to Recommendation Directing the Advisory Committee on Social Witness Policy, in Consultation with Appropriate Entities, to Develop a Comprehensive Serious Mental Illness Policy, Including Justice Issues and Full Participation in the Life of the Church and Report to the 217th General Assembly (2005)—From the Advisory Committee on Social Witness Policy* (*Minutes*, *1999*, Part I, pp. 42.309).

The recommendation read as follows:

> Direct the Advisory Committee on Social Witness Policy, in consultation with appropriate entities, to develop a comprehensive serious mental illness policy, including justice issues and full participation in the life of the church, and report to the 217th [218th] General Assembly (2005) [2008] (*Minutes*, 1999, Part I, pp. 42, 309).

The Advisory Committee on Social Witness Policy (ACSWP) received further instructions from the 213th General Assembly (2001): "Direct the Advisory Committee on Social Witness Policy to instruct its task forces on disabilities and serious mental illness to include the dimension of domestic violence and its impact in their respective work" (*Minutes*, 2001, Part I, pp. 61, 239). In addition, the 217th General Assembly (2006) instructed the Advisory Committee on Social Witness Policy (ACSWP) to "include consideration of youth suicide and self-injury in the ongoing work being done by the Advisory Committee on Social Witness Policy (ACSWP)'s Task Force on … Serious Mental Illness" (*Minutes*, 2006, Part I, pp. 50, 917). This report focuses specifically on issues explored by the task force on serious mental illness, while an earlier disabilities policy*, Living into the Body of Christ: Towards Full Inclusion of People with Disabilities*, treats broader disability concerns (*Minutes*, 2006, Part I, pp. 50, 919–39).

I. Introduction

The biblical theme of "exile" guides this policy statement. After offering a working definition and an account of the historical context, the report focuses on two major themes. The first theme is "The Land of Exile," which explores the difficulties and injustices endured by people with serious mental illness. The experience of mental illness disorders people's lives in ways that exile them from themselves, their families, and their community. The second theme, "God's Call to Comfort," focuses on appropriate ways congregations can minister with and to people with a serious mental illness. Throughout this report, people are understood from a Christian incarnational perspective, called to be delivered from chaos and disorder into the wholeness and communion of salvation. At the same time, the report recognizes the validity of the "medical model," with its gifts of biochemical medication and social-scientific analysis. The goal of restoration from exile includes the integration of both perspectives and the renewal of a healthier culture and society. Especially because this document will be read to give hope to those suffering from mental illness and their families, stories are included from various perspectives that illumine and give depth to this policy statement. The stories have been altered to conceal the identities of the people in them.

A. *God's People in Exile, God's Call to Proclaim Comfort*

> "Comfort, O comfort my people, says your God." (Isa. 40:1, NRSV*)*

God sent the Prophet Isaiah to proclaim comfort to a people in exile, and also to bring that comfort to them in his own person. God's people were suffering from exile from Jerusalem, the center of their covenantal life. It was in Jerusalem that they were able to celebrate and experience the wholeness of life as a people of the covenant with God.

Through the message of comfort, God affirmed that Israel was still beloved, though in exile. The covenant, "I … will be your God, and you shall be my people" (Lev. 26:12, NRSV), was confirmed. This, in and of itself, would bring comfort to an exiled people. God had not forgotten them nor abrogated the covenant with them.

Isaiah's comforting was not to be in words only; his commission to comfort demanded personal involvement in preparing the way for the Lord to come to them. Their deliverance would come through the Lord, who would bring them back to Jerusalem in celebration of the glory of the Lord.

> In the wilderness prepare the way of the Lord, make straight in the desert a highway for our God. Every valley shall be lifted up, and every mountain and hill be made low; the uneven ground shall become level, and the rough places a plain. Then the glory of the Lord shall be revealed, and all people shall see it together, for the mouth of the Lord has spoken. (Isa. 40:3−5, NRSV)

To God's people in exile the Prophet Isaiah declared a message of comfort, and then was commanded to prepare the terrain for the advent of the Lord as Deliverer. Hebrew thought often merged message and deed. Accordingly, the Prophet was bid not merely to proclaim, but also to enact God's message. The Prophet's presence among them brought comfort to them, and embodied the vision that they were to prepare the way of the Lord, so that God might be among them.

Remembering both aspects of Isaiah's call, the speaking and the doing, today our church acknowledges God's call to be among and comfort persons with serious mental illness and their loved ones—persons who all too often have been exiled from the covenant community. Of course, exile may happen for various reasons. Some biblical scholars interpret the Hebrews' exile as the consequence of their disobeying God, thus it is understood as divine punishment. However, persons living with serious mental illness are often exiled by the covenant community not because they themselves have disobeyed God, but because of a lack of information and understanding in the faith community. [Refer to the story of the man blinded at birth (John 9:1−12).]

If we reflect deeply enough we will realize that the people exiled include not only those afflicted with a serious mental illness, and their families and caretakers, but also the covenant community itself; for exiling others alienates the majority and fractures the family of God. The church by its own actions becomes exiled from its holier possibility, the covenant community that it is called to be.

The faces of people with serious mental illness are many. Some in our congregations choose to keep their mental illness private and do not disclose it to anyone in their church. They are fully functional and participate in the life of the church without their mental illness ever becoming apparent. Others' mental illnesses are more evident to the congregation.

Our disinclination to face reality tragically divides our covenant community. Our brokenness prevents us from experiencing the reality that the prophet Isaiah described, and which Christ incarnated: "Then the glory of the Lord shall be revealed, and all people shall see it together, for the mouth of the Lord has spoken" (Isa. 40:5, NRSV).

Christ came to bring reconciliation and wholeness to the broken communities of this world. Realizing that we have exiled others and thereby alienated ourselves from the promised glory of God, the church acknowledges this mandate from the Lord: "Comfort, O comfort my people!"

The Presbyterian Church (U.S.A.) hears this call and seeks to respond through the power of the Holy Spirit, by welcoming outcasts as Jesus did. The Spirit connects us to people wrongly exiled by the social stigma surrounding serious mental illness. That same Spirit that was in Christ calls us to realize that the redeemed covenant community that we cherish is bound together as one family by God's compassion for all. By doing so, we can find healing as we disclose how we are wounded and pray for each other.

As the Church incarnates the love of God that was so evident in Jesus, we experience the joy of the reign of Christ. (cf. Gal. 6:2) The Presbyterian Church (U.S.A.) through this policy acknowledges its complicity in the suffering of people living with serious mental illness, people often exiled from our congregations and our civic communities. Through this policy, we seek to address our ignorance, prejudice, and fears. We acknowledge our call from the Lord to bring comfort to those in exile. Through this policy we seek to be reconciled to one another so that we may become the blessed community celebrating God's gifts to all. We acknowledge that our words must be accompanied by action. Therefore, through this policy we offer ways by which the healing touch of Christ may come upon our faith community, and also upon the more extensive communities in which we live.

The Prophet Isaiah received a call from the Lord to proclaim and to bring comfort to an exiled people. This is the same call to which we, the Presbyterian Church (U.S.A.), must respond today. We walk in faith with the Christ who stepped over social and religious boundaries and dared to touch and heal the lepers of his day. Like the Prophet Isaiah, we are called to be faithful companions of the Lord by breaking down dividing walls that exile us from each other, and celebrating the gift of

community for all people. This policy is offered in expectant thanksgiving to God, trusting that by God's grace we shall all come to see the glory of God together.

B. *Jesus' Ministry of Healing*

In Jesus' earthly ministry he healed many people: through Jesus' healing power the blind could see, and the lame could walk, "and they brought to him all the sick, those who were afflicted with various diseases and pains, demoniacs, epileptics, and paralytics, and he cured them" (Matt. 4:24 NRSV). Many of the people Jesus healed were not just physical cures, but they included restoring a person to ritual cleanliness and therefore full participation in community life (lepers). Some also included a healing of the soul through the gift of forgiveness (the paralytic). Still others included the gift of peace, shalom, and wholeness (the woman with the flow of blood).

In Scripture, it is clear that healing is not confined to physical cure. Therefore, we make a distinction between healing and cure. Cure refers to the elimination of a disease or a disorder. Healing, on the other hand, is something much broader, and may or may not include the elimination of disease or disorder. Healing includes reconciliation, restoration to right relationship, the gift of courage to live faithfully within limitations, internal peace, God's call to vocation, and living a life of prayer, mutually up building interpersonal relationships, committed church life, and self-giving service to the world. People can be healed even when they continue to live with a disease or disorder. Some have discovered that the relentless search for a cure for their disorder is a great burden, and therefore the appropriate hope is for healing, not cure. The challenge for the church is to be an instrument of healing when cure is not likely.

As sovereign over all, God is free to use any means to heal the sick. We may experience God's healing power through healing prayer, laying on of hands, anointing with oil, and the prayers of the church. We may experience God's healing power through participation in the love, nurture, and admonition of the church. We may experience God's healing power through medication and psychotherapy. As spiritual, social, and biological beings, God may extend healing power to us through all three of these means, as well as through surprising, wholly unexpected means.

C. *Definitions*

Millions of people live with mental illness. It is the leading cause of disability in the U.S. and Canada for those between the ages of fifteen and forty-four.[1] Approximately one in four adult Americans has a diagnosable mental illness in any given year.[2] Although "mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion."[3] According to the National Institute of Mental Health (NIMH), one in seventeen or 6 percent of Americans have what can be called a "serious" mental illness.[4] It is serious mental illness that is the subject of this policy statement. In its widespread wake, few families and congregations are left unaffected.

Definitions of "mental illness" and "serious mental illness" vary greatly. In fact, the standard diagnostic manual used by mental health professionals does not even make a distinction between serious mental illnesses and non-serious ones.[5] The task force's mandate, however, was to address serious mental illness. We, therefore, recommend the following definitions:

1. *Mental Illness* is a medical disorder characterized by disturbance in thought, mood, or behavior that causes distress or impairment of spiritual, interpersonal, behavioral and emotional functioning. If left untreated, all mental illnesses are impairing.

2. *Serious Mental Illnesses* are severe and persistent medical disorders characterized by impairment in mood or behavior that cause distress and/or impairment in spiritual, interpersonal, and behavioral functioning. Salient examples are the disorders known as schizophrenia, bi-polar disorder, and major depression. Characteristic symptoms of serious mental illness include hallucinations, delusions, disorganized thinking, extreme mood changes, overwhelming hopelessness and sadness, severely impaired perception, judgment, or insight, and problems with concentration and attention. Serious mental illness is an enduring condition that affects one's ability to cope with everyday challenges. If left untreated all mental illnesses may impair one's ability to establish and maintain interpersonal relationships, practice one's faith, worship God, attend school, go to work, or live independently. All mental illnesses can be impairing.

II. The Church Speaks Again on Serious Mental Illness

The call for justice, care, and hospitality for God's children with mental illness is not new in our denomination. The 200th General Assembly (1988) approved two policies that explicitly called the church to care for and advocate for people with serious mental illness. The first was the policy statement on *Life Abundant: Values, Choices and Health Care*, which affirmed: "Good health—physical, mental health and spiritual—is both a God given gift and a social good of special moral importance. …" (*Minutes*, 1988, Part I, p. 524). The second was the resolution, *The Church and Serious Mental Illness*, which spoke clearly to the church in these words: "The need to address chronic mental illness is urgent" (*Minutes*, 1988, Part I, p. 444).

In the present report, as our church again examines issues of serious mental illness, we do so as a people moved by the suffering of many who live with serious mental illness; and many questions of faith arise from this examination. Perhaps first and foremost is the question of how a good and powerful God can allow such pain. Is not it contrary to the very nature of the God we know in Jesus Christ? To witness the pain among many individuals and families affected by serious mental illness is to press to the limit our faith in God's love and power.

We cannot discern why there is suffering in God's good and lovely creation. We do know, however, that we are created as one body in the image of God, in our shared fragility, shared sin, our need to share God's grace in Jesus Christ, and our call to proclaim God's Kingdom. Therefore, as a church we are called to turn from our sinful ways, to turn from our pattern of exclusion, and to embrace all who live with serious mental illness as sisters and brothers, as co-members of Christ's body endowed with gifts for the upbuilding of the church.

While the church cannot eliminate a person's mental illness, we can welcome people who struggle daily with mental illness and thereby help reduce their suffering by changing chaos into wholeness. The church can recognize that although we might be powerless over some aspects of mental illness, God is not. Through the extraordinary power to love, we can share the precious gift of belonging with persons who have often heard that they do not belong. We can carry the message that by their baptism they bear the indelible mark of belonging to God's family forever. We have the opportunity to participate in the administration of God's grace to those recovering from mental illness, to their families and to covenant communities.

A Mental Health Professional's Story

Having worked for thirty years in the mental health field, I have had the opportunity to follow some clients for a long time. I have watched and worked with them as they struggled to cope and lead meaningful lives, within daunting limitations.

One such client, whose story I have permission to share, has learned to manage his illness and lives independently with the help of a private mental health agency. Our first encounter was on the streets of Atlanta where he often walked back and forth in front of the hospital screaming fragments of scripture and "preaching" to the public.

He was one of our many clients whom the mental services staff referred to as being in a "revolving door," regularly in and out of the hospital without getting any better. He had a difficult time accepting that he had a mental illness. He wanted all of his money, Supplemental Security Income (SSI), at one time so he could buy himself a boat, car, and a chicken farm. Then he could also get a wife.

After several years of missed appointments, being off medications, being arrested then readmitted to the hospital, he was assigned to me for case management. One day during one of our sessions he shared that he grew up in South Georgia. He was born to a single mother but she eventually married and had other children. Her husband never accepted him in the family and thus he grew up living with his grandparents.

His grandparents worked on a tobacco farm where he shared in the work to increase (slightly) the families' take home pay. He was a very angry and bitter teen and one day he got into a fight with the son of the owner of the tobacco farm.

Several days later the police came to his grandparents' home and told them that they needed to send "that boy" away because he was a troublemaker. After weeks of trying to decide what to do, the grandparents gave their sixteen-year-old grandson $45, put him on a bus, and sent him to Atlanta. The family had relatives who lived in Atlanta. Upon his arrival in Atlanta, however, there was no one to pick him up.

In this strange new city, he wandered the streets, ate what he could with the small amount of money he had, and slept in parks and stairwells. He was beaten and robbed. The police arrested him for panhandling. He was mistreated in jail; and when he was released, he said that he felt like he had "lost his mind."

It was very difficult to explain the appropriate approach to managing his life and how to accomplish his goals. Our outpatient case management sessions often ended with him leaving with no resolutions of any of his problems. Eventually I moved to another area in the mental health services and he was assigned a new case manager, but he would turn up in my area just to talk.

In my new support role for him, he asked me to read to him from the Bible. His favorite verses were "Gifts from the Holy Spirit." He enjoyed hearing that he had been given a special gift. He continued to have the same goals and the same problems but as he began to improve on his social skills he also began to improve with his compliance in treatment.

In January 2006, he came to my office neatly dressed saying: "These clothes came from Goodwill." From his coat pocket he proudly pulled out a worn church program, explaining that his sister (actually his stepsister) had given it to him. He added:

"She told me her father had died and gave me this program". Look! This program says that I am his stepson! She told me she was sorry about how her daddy had treated me and wanted me to know that she, her sisters and brothers always told their daddy he had been wrong." During this visit, he shared that he had a new job washing dishes at a local "fancy" restaurant in downtown Atlanta. He said: "The man knows I have a mental illness, but he said I am the best dish washer he has ever seen." Then he smiled and put the worn program in his pants pocket.

III. A Brief History of God's People in Exile

A. *Varied Responses to People with Serious Mental Illness*

Mental illness has been present in every culture and age; and life in exile from community has been the fate of millions of God's children who live with mental illness. At times they have been the victims of unspeakable cruelty. People with mental illness have been burned at the stake as witches, lobotomized, subjected to painful medical experiments, confined in prisons, tortured, and executed. Yet at other times people with mental illness have remained a part of the community, living at home within families where their symptoms were accepted. Responses to people with mental illness have varied widely, ranging from forbearance and kindness to abandonment and exile.

Some interpret Jesus' casting out demons to be healing mental illness, and some also understand mental illness today as a form of demon possession. It is true that mental illness can cause great suffering for those who live with it and for their families—a suffering so great that it seems that something very evil must be causing it. We know from the New Testament gospels many reports that Jesus "cast out demons." The personification of evil that is found in those accounts seems to refer to real influences that bring chaos into human life. For example, in the fifth chapter of the Gospel of Mark, Jesus is confronted by "a man out of the tombs with an unclean spirit" (Mark 5:2, NRSV). The man's life is full of disruptive chaos in his inner experience and his outward behavior. With divine power and authority, says the gospel, Jesus freed the man from disordering influences, restoring him to balance, self control, and appropriate behavior in his community. "And he went away and began to proclaim in the Decapolis how much Jesus had done for him; and everyone was amazed" (Mark 5:20, NRSV).

Whatever may be the ultimate nature of the disordering influence in this account (which remains to some degree mysterious to us), there seem to be very few instances in our modern experience of such miraculous deliverance. The Church today seems called to employ far less dramatic and more clinical means to assist those afflicted with serious mental disorder*s* to gain some measure of healthy order*,* balance, self control, and appropriate behavior. Our role in healing and treatment follows the counsel of the Apostle Paul in Philippians 4:8, NRSV: "… whatever is true, whatever is honorable, whatever is just, whatever is pure, whatever is pleasing, whatever is commendable, if there is any excellence and if there is anything worthy of praise, think about these things." In that light, we turn both to the truth, honor, excellence, etc., of modern medical science and to the love and grace of our Lord Jesus Christ as they are embodied in the life and worship of the Church.

We recognize that schizophrenia, bi-polar disorder, and major depression must be addressed medically. We also recognize the Church's responsibility to welcome and care for those afflicted with these disorders and to employ the rich means of grace that are essential to the Church's life to aid in their healing and restoration. We believe that it is therefore not useful or appropriate to attribute serious mental illness to "the work of demons," though we recognize that there are powerful disordering forces at work in all of human life – many of which do not appear at all demonic but which do bring chaos with them.

As serious mental illness came to be treated more constructively and compassionately, a more general acceptance of counseling and psychotherapy developed in society. The Church contributed significantly to this process through the work of hospital chaplains, leading to the development of clinical pastoral education, and through the pastoral counseling movement, leading to the placement of counseling or "mental health" centers in many churches. These innovations added new dimensions to the traditional pastoral "cure of souls" and can be counted among the twentieth century achievements of the ministry and witness of the "mainline" church.

B. *From the Mental Hospital to the Prison*

In the early twentieth century in the United States (U.S.), the predominant response to mental illness was either voluntary or involuntary confinement to large state hospitals. Until the 1950s, hundreds of thousands of people were in such institutions. Several factors led to a new chapter in society's response to people living with mental illness. First, new medications created the hope that people with a mental illness would be able to live outside institutions and participate in community life. Secondly, the public became aware of widespread cruelty and neglect in many state mental hospitals and began to call for closing them. Thirdly, the public became concerned for the civil rights of people involuntarily committed to mental hospitals.

Over the next few decades, thousands of residents of mental hospitals were released. The official plan was to create a nation-wide network of community-based mental health centers that would enable them to live on their own, supported by medical and social services. However, this network of centers never materialized, for lack of funding and community support. Though many of the former patients could have lived independently with adequate support, without it they could not main-

tain a safe and healthy life. Some stopped taking their medications, and their painful and debilitating symptoms returned. Some turned to alcohol and abuse of other substances as a way to control the symptoms. Many, unable to find or maintain housing and employment, became homeless.

Without social support, medication, housing, or treatment for their mental illness, some lived on the streets and engaged in bizarre public behavior. A small fraction threatened public safety. For mostly minor but sometimes major infractions, more and more people with mental illness ended up in prison. Today, more than half of the people in our prisons have some kind of mental health problem, and some of them are very serious: "an estimated 15 percent of State prisoners and 24 percent of jail inmates reported symptoms that met the criteria for a psychotic disorder."[6]

Incarceration has become a widespread response to the mentally ill in the U.S. Over the course of several decades, we have witnessed a process of "trans-institutionalization," that is, a shift from one institution to another: from large mental hospitals to prisons. In fifty years the number of people with mental illness living in hospitals dropped from 560,000 to 70,000, while the number of mentally ill people in prisons rose dramatically.[7] Prisons, of course, are not designed to provide the social support and attentive psychiatric care that many persons with serious mental illness require.

C. *Still in Exile, Still Without Comfort*

Like the people of Israel in exile, many people with mental illness remain outsiders, excluded from the warmth of family, friends, and even the church. People with serious mental illness are excluded for many reasons. Some people believe that all people with mental illness are dangerous and violent, or fear that their illness might be contagious; others just fear their unconventional or inappropriate behavior. Our churches should educate their members about serious mental illness and build understanding among all the members of Christ's body. We recognize God's call to proclaim comfort to people in exile by welcoming them home into the covenantal community of the church. If the church answers this call faithfully, the rest of God's church shall find its way out of exile too: our exile from the possibility of becoming the loving community which God calls us to be.

IV. The Land of Exile

> By the rivers of Babylon—there we sat down and there we wept when we remembered Zion. On the willows there we hung up our harps. … How could we sing the Lord's song in a foreign land? (Ps. 137:1–2, 4, NRSV)

A. *Lives in Exile*

The United States' history of failure to provide adequate care for people with serious mental illness has been devastating. Our neglect has contributed to (1) homelessness, (2) addiction, (3) incarceration, and (4) suicide for many, as described below.

1. *Homelessness*

Though only 6 percent of the U.S. population has a serious mental illness,[8] this portion constitutes 20 to 25 percent of the homeless population.[9] Furthermore, they are "homeless more often and for longer periods than other homeless groups."[10] Also, as many as two-thirds of all people with serious mental illness have experienced or been at risk for homelessness sometime in their lives, although only 5 percent of people with serious mental illness are homeless at any given time.[11]

There are many reasons why the homelessness of persons with mental illness is a very difficult problem to address. Independent living often requires supportive services, which society has failed to provide. Substance abuse, which plagues approximately half of the people with a serious mental illness, further complicates their maintaining permanent housing. In addition, many people with serious mental illness have not received the benefits to which they are entitled by law, and therefore cannot afford housing. Sometimes they stop seeking mental health services because of a history of unsuccessful attempts. They are often alienated from family members although they maintain lengthy relationships with other homeless people. They are twice as likely as other homeless people to be arrested or jailed, mostly for misdemeanors.[12]

2. *Addiction*

Many people who live with serious mental illness struggle with both a mental disorder and an alcohol or drug addiction. These persons with a dual diagnosis represent about one half of patients seen in psychiatric emergency rooms. More than half of the people who abuse drugs and or alcohol have at least one co-occurring mental illness. Of the persons who use cocaine, three out of four have a co-occurring mental illness. For those who abuse alcohol, one-third has a mental disorder.[13]

It is estimated that between 32 to 41 percent of individuals with a mood disorder have a substance abuse disorder. Persons with a bipolar disorder have the highest rate, 56 to 71 percent. Approximately one-half of persons with a psychotic disorder, including schizophrenia, also have a substance abuse problem.[14]

Alcohol abuse and chemical dependence are complicated disorders that are impacted by multiple factors. When existing alone, they are thought of as biological, medical disorders, or diseases. A person with mental illness may seek relief from symptoms by using alcohol or drugs. For example, a person with bipolar illness who cannot sleep may use alcohol or sedating drugs in an attempt to sleep or slow down. This self-medication may provide temporary relief, but it tends to worsen mental illness symptoms in the long term. In addition, it may contribute to noncompliance with treatment and medication regimes and increase the risk for adverse interactions with prescribed medications.

Substance use disorders may also mask the symptoms of a mental illness. For instance, when someone with a mental illness feels an intensification of their symptoms approaching, they may try to convince themselves and others that their symptoms are due to the substance abuse and not from mental illness. When mental illness symptoms are attributed solely to the effects of substance abuse, both disorders become more difficult to diagnose and treat.

Although personal responsibility is important in addressing substance abuse problems, alcoholism and drug addiction are illnesses in their own right. These illnesses are not the result of character flaws or poor moral choices. Recognizing their own powerlessness to overcome their addictions, people in twelve step recovery programs do in fact make progress against old habits by turning their lives over to a higher power. Involvement in church life can help to support them by giving their lives a meaningful context.

A Story of Recovery

I awoke from a nightmare of such extreme intensity that the commonplace became confusing and threatening. The familiar had become a bizarre blurring of the real and unreal, producing in me a gut-wrenching fear. My sense of time had disappeared. Even when I was awake, this “nightmare” continued through sleepless days and nights. I was bone tired, but my mind raced. When I felt a yawn coming on, I was unable to give into it before being carried away by a surge of frenzied energy. I was bereft of rest, and clarity of mind and perception. My thoughts were strewn with suspicions and delusions. I thought the Second Coming of Christ was imminent, but somehow that I alone was gifted with special powers to save the world. My sense perceptions seemed extraordinarily focused. Sometimes I thought I could see things that others could not. Stymied by the fact that other people were not validating my perceptions, I became isolated. My friends and family left me. I could no longer work. I lost my home, my freedom, and my sanity. My world came crashing down.

Although these experiences were the result of my addiction to prescription drugs (psychostimulants) and alcohol, there are many parallels between my mental disorder and those suffered by others who have a serious mental illness. While my story is of a person without a dual diagnosis, the symptoms induced by substance abuse are similar to symptoms associated with serious mental illness and worsened when there is a dual diagnosis condition. Unlike people with a serious mental illness, people with exclusively substance dependence can correct their brain chemistry once their substance abuse stops. Unfortunately, for those with a serious mental illness, this is not the case, for some will have to endure symptoms such as these throughout their lives.

This is how I began my recovery. Over time, my mind began to clear. Since I had been trained at Harvard Medical School, I was ashamed of my behavior. But my need for help outweighed my need to protect my pride. So, I got into treatment and began a lifelong discipline of recovery through the twelve-step program of Alcoholics Anonymous, and also through active involvement in a very supportive church, where my isolation was met with fellowship, my fears with compassion, and where my weaknesses were forgiven, and my service encouraged. I was able to return to work in my profession as a clinical psychologist. My personal experience is now being used to help others ravaged by mental illness.

I have discovered on my journey of recovery that chemical addictions and alcoholism are diseases, similar to physical disorders such as hypertension and diabetes. I have also come to realize that addictions are no respecter of persons. They can affect people who are highly educated and “ought to know better.” Fortunately, there are treatments available to persons with addictions and other types of mental disorders. The church plays an important role in recovery. In recovery, I have learned to more fully participate in life by appreciating my Creator’s daily gifts. I have reconciled with my wife, family, and community, and am keenly aware of my dependency on God’s grace; for without such grace, I would not be in the healthier place where I now am.

3. *Criminal Justice System*

Three times the number of persons with mental illness are in our prisons as are in our psychiatric hospitals.[15] Yet inmates rarely receive the treatment to which they are legally entitled. In the report entitled “Mental Health Problems of Prisons and

Jails" published on the Department of Justice's website, more than one-in-six jail inmates, one in three state prisoners, and one in four federal prisoners with a mental health problem received treatment for their condition since their admission.[16]

Life in prison for a person with serious mental illness is extremely difficult and prisons are ill-equipped to offer appropriate mental health services. "Few prisons offer adequate mental health care services, and the prison environment is dangerous and debilitating for prisoners who have mental illness. These prisoners are victimized by other inmates, punished by prison staff for behaviors associated with their illnesses, and often placed in highly restrictive cells that exacerbate their symptoms," writes William Kanapaux in *Psychiatric Times*, summarizing a report by Human Rights Watch (HRW), released in October, 2003.[17] The President's New Freedom Commission on Mental Health Final Report confirms the right to adequate mental health care for people in prison: "Providing adequate services in correctional facilities for people with serious mental illnesses who do need to be there is both prudent and required by law. The Eighth Amendment of the U.S. Constitution protects the right to treatment for acute medical problems, including psychiatric problems, for inmates and detainees in America's prisons and jails."[18] However, inmates are often not provided access to necessary medication or to the mental health providers they need.

Not only are people with serious mental illness over-represented among those serving prison terms, but also among those condemned to death by the state. Amnesty International (AI) reported that at least 10 percent of the first one thousand people executed in the United States since 1977 were severely mentally ill.[19] The Mental Health America (MHA) reports that 5−10 percent of the 3,400 people on death row in the U.S. are mentally ill.[20] These statistics are undoubtedly underestimated since in many cases there have been no psychiatric evaluations. Dr. Susan Lee, Amnesty International's American programs director states: "Prejudice and ignorance give rise to fear; and for many people it is easier to sentence a mentally ill person to death than to find genuine treatment solutions."[21] Our failure to care for people with serious mental illness has had deadly consequences for those on death row.

4. *Suicide*

Jonathan's Story

In 2005, Jonathan (age twenty-five) returned from military service. He was repeatedly shaken by flashbacks of sixteen men in his unit who died during two days of intense fighting. In addition to waking flashbacks of the events of this period, Jonathan was also troubled by terrifying nightmares which left him feeling guilty for not being able to protect his buddies, and guilty for surviving what they did not. At first Jonathan resisted seeking mental health treatment because that seemed to him a sure admission of weakness. However, when panic attacks became intolerable he finally sought help through the Veterans Administration. Help came too slowly. After weeks of outpatient processing and a lack of inpatient beds, Jonathan committed suicide.

Like Jonathan, some sufferers conclude that life in exile is unbearable and choose to end their lives. Globally it has been estimated that nearly a million people take their own lives each year. In the U.S., the annual suicide rate is approximately 12/100,000.[22] According to the National Co-morbidity Survey Replication, 3.3 percent of the general population thinks about committing suicide in the course of a year. Most suicide attempts involve an individual with a mental disorder, particularly mood disorders and/or substance abuse disorders. Suicide rates among bipolar persons have been estimated at between 15 to 20 percent, with attempts as high as 50 percent.[23] According to the National Institute of Mental Health, "Four times as many men as women die by suicide[24]; however, women attempt suicide two to three times as often as men."[25]

Several risk factors have been correlated with suicide and suicidal behavior. These include:

- age (elderly and adolescent);
- gender (male);
- race (Caucasian);
- religious affiliation (Protestant);
- marital status (single);
- employment status (unemployed);
- economic status (lower annual per capital income);
- physical health (persons with serious physical illness);
- previous suicide attempts;
- those who have poor social support or have lost such support altogether (as when a friend, family, or church member moves away or dies);
- those in personal crisis (such as recently divorced or bereaved persons);
- those with a prognosis of terminal illness;
- those having less access to mental health resources and federal aid;
- those having a history of emotional or sexual abuse; and
- those living within certain geographical areas (the reasons for this last factor are sometimes not well understood).[26]

In addition to these risk factors, certain childhood adversities have been associated with a risk for suicidal behavior. These include childhood maltreatment or victimization (psychological, physical, and sexual abuse), problematic parenting or family environment, (family history of suicidal behavior, chronic and severe conflicts with family members), difficult relationships with peers and socioeconomic hardship.[27] Suicidal behavior may be attributed to biologically inherited mental disorders as well as environmental stressors and traumas.

a. *Suicide Among Teens*

"Suicides among young people nationwide have increased dramatically in recent years" states the American Academy of Child and Adolescent Psychiatry (AACAP).[28] Suicide is so prevalent in youth that it is the third leading cause of death for those between the ages of fifteen and twenty-four, preceded by homicide and car accidents.[29] Each year, approximately five thousand people in this age range die from taking their own lives. Although staggering, this figure may actually be under-representative due to the stigma associated with suicide. One recent study indicated that one in four high school students seriously considered suicide. One in six made plans to attempt suicide and one in twelve tried to carry their plans out. Although Caucasian students were more likely than black students to consider suicide, there has been more than 100 percent increase in the rate of suicide among African American males.[30] Correspondingly high numbers of suicide attempts occur among Native American and Alaska Native youth. A dramatic elevation in suicide rate is also evident among gay and lesbian high school students. One study showed that gay and lesbian high school students were four times more likely to attempt suicide than heterosexual students.[31]

Teens face multiple pressures. They need to adjust to bodies that are in flux. They face independence. They have high expectations of themselves and sometimes face strong pressures from parents. They have a strong need to be accepted by peers. When these developmental tasks are frustrated, they may become dejected and express their anger and despair through suicidal acts. For teens who are susceptible to a serious mental illness, stresses such as excessive and intense family arguments, worry over grades, or the breakup of a romantic relationship may trigger suicidal behavior. Warning signs of suicide risk include extreme personality changes, loss of interest in routine activities, withdrawal, increased irritability, prolonged sadness, substance abuse, and a preoccupation with death.[32]

b. *Suicide Among the Elderly*

Elderly people are disproportionately likely to commit suicide. In the year 2000, elders constituted 13 percent of the U.S. population. Disproportionately, individuals sixty-five years and older accounted for 18 percent of all suicides.[33] Risk factors for suicide among elders differ in some ways from those among younger people. The elderly show a higher prevalence for depression and other serious mental conditions. They experience poorer social support, lower economic status, and serious physical health conditions that diminish their quality of life. Elderly people also use more deadly means when they attempt suicide, so the probability that they will survive is less than that for younger persons.[34] Younger people sometimes make a weak suicide attempt to get attention. This is rare among the elderly.

Many elderly people who attempt suicide never seek professional care for mental anguish, though some research reports that almost half the patients who committed suicide had visited a physician in the preceding week.[35] So, detecting depression among the elderly is a crucially important role for primary care providers.

B. *Discrimination Against the Stranger in a Strange Land*

Many people with serious mental illness do not face such overt problems as homelessness, addiction, or imprisonment, as described above. Yet, solely on account of their illness they struggle with society's sometimes subtle but nevertheless destructive attitudes toward persons with a serious mental illness. The stigma of having a serious mental illness may deprive them of employment or adequate health care; or they may face the possibility of inappropriate involuntary commitment.

1. *Stigma*

When a person is physically ill, it is expected that they will be supported and treated sympathetically in their quest for healing. When one has a long-standing, disabling illness or injury, it is expected that they will be given every assistance and consideration as they cope with their limitations and any ensuing hardships. Not so with mental illness. Not only must those who are diagnosed with a serious mental illness cope with the illness as such, but they, and their families, must also shoulder the additional burden of the nearly overwhelming presence of stigma.

Stigma is a mark of shame, disgrace, or disapproval; it is a sign that one is different from others and should be rejected because of that difference. "Stigmata" were literally cut or burned onto the bodies of "different" individuals in ancient Greece and they were shunned. Today stigma takes the form of negative, inaccurate stereotypes, ostracism, and cruel, ignorant humor. Stigma prevents ill persons from seeking treatment in a timely fashion. It diminishes public support for funding of necessary and appropriate services for the mentally ill. It prevents persons who are in recovery from finding meaningful and se-

cure employment and acceptable housing. Stigma enables the insurance industry to impose a life time limit on the number of days for inpatient treatment. It contributes to cruelty in our criminal justice system. Stigma precludes persons with mental illness from seeking and receiving the gift of community and, most importantly, it denies to those who live with mental illness God's gift of hope. Although its effect is much the same for the members of all groups, stigma can be particularly harmful to some racial/ethnics and immigrants with a mental illness because of the already existing burden of discrimination they bear.

To begin to redress the consequences of stigma one must recognize that its roots are to be found in our own fears. If we recognize that a person with mental illness is the same as any other person in every regard except that they have a particular illness, then we must recognize that we too could be subject to such an illness. As psychiatrist R. E. Kendell writes, "Our concept of ourselves as rational beings guided by reasons and intelligence is crucial to our self confidence and self esteem; and encountering a fellow human being who has lost his or her reason and whose behavior is no longer rational is profoundly disturbing because it implies that the same might happen to us. That is why the mentally ill are mocked as well as feared, for mockery reduces the implied threat they pose."[36]

Many mental health professionals and individuals living with mental illness believe that media sources are a major contributor to the long lasting negative attitudes toward mental illness held by the public. Media sources are held responsible particularly for promulgating the notion that there is an extraordinarily high correlation between mental illness and violence when, in fact, "… the overall contribution of mental disorders to the total level of violence in society is exceptionally small."[37] Some media sources do much to legitimate the notion that persons with mental illness are an appropriate subject of humor and derision. Much of the content of both television and film contains demeaning terminology and caricatures that are hurtful to individuals and perpetrate centuries-old stereotypes. The same is true of conversation in public life and in private among persons who have no intent to hurt, but who fall victim to habits of expression.

The authors of the landmark Surgeon General's report of 1999 state very explicitly, "Stigma must be overcome. Research that will continue to yield increasingly effective treatments for mental disorders promises to be an effective antidote. When people understand that mental disorders are not the result of moral failings or limited will power, but are legitimate illnesses that are responsive to specific treatments, much of the negative stereotyping may dissipate."[38] Our church can be a powerful force in overcoming stigma by modeling for the rest of society how those living with a mental illness must be regarded—with respect, as loved children of God, and with deep appreciation for the unique gifts they bring to the community where they, too, are recognized as members of the Body of Christ.

2. *Limited Employment Opportunities*

According to the results of a comprehensive federal commission on serious mental illness, "among adults with serious mental illness there is a 90 percent unemployment rate—the worst level of unemployment of any group of persons with disabilities."[39] At the same time, though, studies show that many persons with serious mental illness want to work and could do so with moderate assistance. The commission also finds unacceptable that our nation's largest "program" for people with mental illness is disability payments rather than assistance in finding meaningful employment with benefits, job transition, and vocational rehabilitation.

3. *General Health Care*

Numerous studies have consistently shown that persons with mental illness have a higher mortality rate than the general population. They also have extensive medical needs that go undetected and untreated such as diabetes, accidents, and heart disease. "People being treated for serious mental illness by public mental health systems die 25 years earlier, on average, than do members of the general population."[40]

Various obstacles prevent people with mental illness from getting the medical help they need. Individuals with severe mental illness can be unwelcome in medical offices because they appear disheveled, have poor hygiene, and display idiosyncratic mannerisms. Their mood and thinking disturbances may elicit negative reactions. As a consequence they may receive only a cursory examination. Also, mental illness can create distortions in physical sensation, pain perception, and accurate reporting. A clear and complete history, without corroborating information obtained from others, such as a family member or friend, is difficult to obtain.

Some people are denied appropriate physical care due to the prior diagnosis of mental illness. The medical staff might focus on the mental illness to the exclusion of the physical ailment. The primary diagnosis may become the only diagnosis.

Some people with mental illness choose to avoid medical treatment altogether because of a general fear of others, especially medical personnel who are perceived as untrustworthy. Simple things such as making appointments, observing waiting room protocol, filling out forms, compliance with treatment recommendations, getting prescriptions filled, and seeing specialists can be overwhelming.

4. *Involuntary Commitment*

Decisions about the civil rights of persons with mental illness become particularly difficult when they are not a danger to themselves or others but their untreated illness leads them to live in inhumane conditions of deprivation and suffering. In this situation, does a loved one have a right to force them into treatment against their will? Some families have experienced the tragic cycle of their loved one going off medication, becoming unable to care adequately for themselves, being arrested and incarcerated, then released to the care of the family, only to go off their medications again and begin the cycle once more. In this case, should the family make treatment decisions on behalf of a loved one that might include committing him/her involuntarily to a hospital?

Decisions about civil rights for people with mental illness become difficult when untreated illness leads to inhumane conditions of deprivation and suffering. When a person's ability to assess her or his options has been gravely disordered by mental illness, does this responsibility fall rightly to loved ones? The National Alliance on Mental Illness (NAMI) has adopted the following statement regarding involuntary commitment that allows for greater consideration of individual circumstances. Rather than opposing without exception all involuntary commitment outside danger to self or others, NAMI recommends that:

> States should adopt broader, more flexible standards that provide for involuntary commitment and/or court ordered treatment when an individual is gravely disabled, which means that the person is substantially unable, except for reasons of indigence, to provide for any of his or her basic needs, such as food, clothing, shelter, health or safety; or is likely to substantially deteriorate if not provided with timely treatment; or lacks capacity, which means that as a result of the brain disorder the person is unable to fully understand; or lacks judgment to make an informed decision about his or her need for treatment, care, or supervision.[41]

On the other hand, does the person living with mental illness have a right to the final say over his or her medication and treatment? Does she or he finally know what is in her or his best interest? Individuals ought to be free to make decisions before God about how to respond to their illnesses. One way to protect the individual rights of a person with mental illness is through Psychiatric Advance Directives (PADs). (Refer to Appendix D for an example of a PAD) By stipulating in writing and in advance their decisions regarding their own care, people with a serious mental illness can provide very helpful guidance to their families and mental health providers, to be used in the event that their illness becomes acute. This practice ensures that the will of the person with the debilitating mental illness is respected.

C. *Comfort Withheld: Inadequate Mental Health Care*

Our understanding of comfort for people with mental illness includes hospitality, affection, and nurture, as well as advocating for their access to the goods of society, including timely and excellent mental health care. Tragically, government funding for these services has been cut again and again. The church faithful to both God and to God's children who live with mental illness will engage in the struggle to make quality mental health care available to any who need it.

1. *Barriers to Mental Health Services*

According to a 2000 World Health Organization study, mental illness is the leading cause of disability worldwide. The study also concluded that mental illness is responsible for 25 percent of all disability in major industrialized countries.[42] Yet, "… only one out of two people with a serious form of mental illness seeks treatment for the disorder."[43] According to the President's New Freedom Commission on Mental Health, nearly all the citizens who are not receiving care are in that predicament because access to care is impeded. Though there are instances of persons simply choosing not to seek treatment, untreated mental illness can usually be accounted for by multiple obstacles to treatment. Some of these obstacles are a lack of transportation, the unavailability of childcare, the inflexibility of employers, the stigma of mental illness, and cultural or language barriers. Persons who need treatment will often not seek it for fear of being labeled "lazy," "crazy," "dangerous," or worse. They fear the inability to obtain employment, ostracism, and, ultimately, abandonment by society.

Chief among the obstacles to getting treatment, however, is the real or perceived inability to pay for the needed services. Many persons with mental illness lack health insurance altogether. They are unemployed, homeless, and perhaps addicted, and have either not sought or qualified for any public assistance. Others are insured, but not sufficiently. Those who rely on third party payments to pay for their mental health care often find that there are limits upon the services and medications covered. The President's New Freedom Commission wrote in 2000, "The current system of mental health care must rely on many sources of financing. Too many of the funding streams are tightly restricted regarding how they may be used and for whom. Providing access to effective treatments and services that are easy to navigate and that use flexible funding streams is crucial to transforming mental health care in America."[44]

An additional obstacle is posed by the insufficiency of inpatient psychiatric beds, especially for children and adolescents and for those living in sparsely populated states or regions. It is not uncommon for patients, including children, in some areas of the U.S. to be hospitalized hundreds of miles from home and family because no hospital beds exist or no beds are available

in their home community. This possibility can often dissuade individuals from seeking and/or accepting treatment for themselves or family members.[45]

2. *Lack of Insurance Parity*

In the 1999 Surgeon General's report on mental Illness cited earlier, it is noted that people who suffer from mental illness are least likely to receive the medical attention that they need. One of the major reasons for this failure is inadequate insurance coverage, which makes mental health care unaffordable.

Insurance coverage for mental illness has long been separate from and unequal to general health insurance. Mental illness coverage is much more restricted than coverage for other illnesses, such as heart disease, cancer, and diabetes. Limits on hospital stays, restricted numbers of psychotherapy sessions, higher co-payments, monthly limits on prescription drug costs, and caps on lifetime benefits are ways that insurance companies try to contain the cost of mental health coverage. Furthermore, accessing this coverage is complicated and confusing because insurance companies have "carved out," or separated, plans of coverage for mental health care. These "carved out" plans are run by subcontracted companies whose only task is to manage mental health services. The separate but unequal insurance coverage for mental illnesses has been called a lack of "insurance parity."

Tight restrictions imposed by insurance companies pose major barriers to obtaining timely mental health care. This generally means that at some point a person with mental illness must either enter the public health care system or receive no care at all. Individuals affected by mental illness report managed care is an immediate barrier and is often one of the primary reasons for the delay of treatment, especially for individuals who experience their first symptoms/episode of mental illness. The longer the delay in treatment the more costly the treatment will be when one does enter the health care system. "Untreated mental illness costs American businesses, government and families at least seventy-nine billion dollars annually in lost productivity and unemployment, broken lives and broken families, emergency room visits, homelessness and unnecessary use of jails and prisons."[46]

Studies show that there is no financial justification for a lack of insurance parity. Advocates such as the National Alliance on Mental Illness (NAMI), the National Institute of Mental Health (NIMH) and the Presbyterian Serious Mental Illness Network (PSMIN) support efforts to stop discriminatory insurance practices against those with mental illness. In 2005, NAMI researched and published "Grading the States: A Report on America's Health Care System for Serious Mental Illness" which disputes the insurance industry's claim that caring for persons with mental illness costs more and requires stringent management. In addition, a study in the *New England Journal of Medicine* concluded that the implementation of parity, when coupled with management of care, could improve insurance protection without increasing total costs.[47]

3. *Managed Care*

Managed Care is a controversial issue when discussing insurance coverage for people with mental illness. Insurers' explanations for higher co-pays, limited life time coverage, and limited number of days in the hospital is confusing and complicated, especially to individuals and families affected by mental illness.

Individuals affected by mental illness report that managed care is an immediate barrier and is often one of the primary reasons for the delay of treatment, especially for individuals who experience their first symptoms/episode of mental illness. While managed care has made it possible for more people to receive treatment for mental illness, it has resulted in more delays and less comprehensive treatment, according to the Rand Corporation's division on health, Rand Health:

> When unmet need is defined as *delays in receiving treatment* or *receiving less treatment than desired,* persons in managed care had unmet needs more often than those in unmanaged care. In contrast, when unmet need is defined as *no care,* those in managed care had unmet needs less often. Although managed care may make it easier to access some treatment, it may make it harder to get comprehensive care [emphasis in original].[48]

The National Alliance on Mental Illness (NAMI) has published a report which cites the failure of managed care plans in many areas, including, "easy hospital admission and flexible hospital length-of-stay … immediate access to all effective medications, suicide attempt viewed as a medical emergency, [and]… consumer and family participation in their treatment planning and care."[49]

Despite the lobbing efforts of the largest advocacy group in this country, the National Alliance on Mental Illness (NAMI), and many other faith-based groups, Congress has failed to pass a bill requiring equal payments for mental health coverage. Such a bill would greatly enhance access to quality, timely, and affordable mental health care.

4. *Obstacles to Obtaining Available Federal and State Benefits*

Persons with mental illness commonly encounter obstacles when trying to obtain federal and state benefits and services. The President's New Freedom Commission on Mental Health wrote in 2003, "consumers (users of mental health services)

often feel overwhelmed and bewildered when they must access and integrate mental health care, support services, and disability benefits across multiple disconnected programs that span federal, state and local agencies. ...”[50] Initial obstacles encountered include: limited knowledge of what benefits are available, the criteria for qualification, and cumbersome, lengthy, and confusing application procedures. In addition applicants are often refused upon their first attempt and must apply again. Therefore most applicants need help through the application process.

Evidence shows that the more serious a person’s mental illness, the harder it becomes to receive the treatment and assistance required by law.[51] There is also strong evidence that due to delays in seeking and qualifying for benefits, many are forced into homelessness and commit petty crimes, such as panhandling and shoplifting, in order to survive.[52]

Discharge plans are often inadequate. Patients leave the hospital without housing, or the means to secure food and needed follow-up medical services. Lacking the necessary information and skills to obtain such basic resources, persons with serious mental illness will likely be hospitalized again. In a similar manner, thousands of persons with mental illness who are released from prison have no access to basic necessities. The President’s New Freedom Commission found that, “… one of the groups most isolated from society are consumers who attempt to return to the community after being incarcerated. Linking people with serious mental illness to community-based services … is an important strategy to reintegrate [persons with mental illness] into their communities.”[53] Failure to do this for a population that is commonly “poor, uninsured, disproportionately members of minority groups, homeless, and living with co-occurring substance abuse and mental disorders”[54] makes it “likely that they will continually recycle through the mental health, substance abuse, and criminal justice systems.”[55]

In addition to the complicated process for obtaining assistance, there are also practical obstacles, such as getting transportation to and from medical appointments, securing child-care during those appointments, gathering necessary documents (e.g., birth certificate, driver’s license, and proof of legal residence), obtaining an address for receiving benefits, making banking arrangements, and finding interpreters for non-English speakers. “Overwhelm[ing]” is the word used by The President’s New Freedom Commission to describe this process.[56] When a brain disorder impedes a person’s concentration, memory, and ability to organize and plan, the application for government benefits is often close to impossible and requires much assistance from others, such as family, friends, and the church.

D. *Families in Exile*

Serious mental illness renders not only an individual in exile, but whole families as well. Below are the stories of two different, unrelated families. The first is the story told by the mother of an adult son who receives a diagnosis of a serious mental illness. The second story is told by the daughter of a woman with a serious mental illness but who never receives treatment.

A Mother’s Story

It had been a frantic spring and summer. In the space of a just a few weeks, our twenty-two year old daughter moved from our small town to a large metropolitan area three hundred miles away. Our younger son and his fiancé announced in March that they were getting married in May, instead of waiting a year as they had been planning. So my husband and I drove U-Hauls, hosted a wedding, served on our church’s session and on a pastor nominating committee, helped care for our own parents who were ninety-three and ninety-five respectively, and worked with our oldest son to help him purchase a first home. In other words, life was happening. And, then, one fall day … the phone rings.

At the other end of the phone is our twenty-six year old, newly married son, now living twelve hundred miles away, who says, “Mom, I need to tell you something … I’ve been feeling really strange lately and I’ve been hurting myself.” My mind had no idea what this meant, but my stomach did. I was instantly sick … I wanted to throw up … my skin crawled … I knew I had entered a place I had never been before.

I tried to keep my voice light, “What do you mean, hurting yourself?”… “I’ve been hitting my head on the concrete blocks in the shower at the gym. I don’t have any skin left on my forehead.” … “Why, why are you doing this?” … “I don’t know, Mom, but I’m scared. Cary [his new wife of five months] says I need to see a doctor. Do you think I should? … “ “Oh, yes, honey, I do. Do you want me to come out to go with you?”… “No, that’s okay, Cary will go with me. I’ll let you know what the doc says, okay?”… “Okay, I’ll be waiting to hear. Love you.”… “Love you too, Mom. Bye.”

In that way, in the space of five or six minutes, life changes—completely. My world was suddenly an unknown landscape where I anticipated assault at every turn. I got through the following day —a day filled with a sense of overwhelming grief; already, I knew my son’s life was irreversibly altered. I grieved his losses—and mine. Finally, in early evening the call came; the doctor had been seen. And I discovered inside this frightened young man a strength I had never suspected. “Mom,” he says, “the doctor thinks I should go into the hospital and I agree. I’m going to check in at 6:30 in the morning.” “What hospital?,” I ask. “A psychiatric hospital,” he says. All of my worst imaginings are confirmed, but he is clearly relieved and, while the anxiety is there in his voice, he is purposeful. I say to him—as I would say a thousand times over in the coming

years–"You've made such a courageous decision; we couldn't be more proud of you." And then the practical emerges, "How will you cover the expense, will your insurance take care of it?" "I think so," he says. "Well, don't worry," I say, "we'll manage it and Dad [a stepfather who has been his Dad since the age of five] and I will get the earliest flight we can get in the morning." "Okay, Mom, see you both when you get here and, Mom, I'm going to be okay."

It suddenly hits me—with all that he is struggling with, he's worried about me. And with that realization, the pain became unbearable and I sobbed. At this point his father and I felt we had two options—pull further and further into ourselves and become more and more overwhelmed by our fears or share this heartbreak with people we knew loved us and would want to be with us in a time such as this. We chose the latter. We made two phone calls. They were not to other family members but to our pastor and to two other church members and dear friends. The three of them were at our kitchen table within the hour. We talked, we cried, we prayed. Of course, the love and companionship of our pastor and friends did not allay all of our anxiety. Nor, did our firm belief that Christ was with us at that kitchen table take away all of our fears, but the communion at that table did make it possible for us to get through the evening and to take the necessary next steps to get to our son's side.

I thought I had done things in my life that had required me to muster all the strength of will that I possessed. I was wrong; nothing had been required of me compared to finding the strength to open the door to that locked hospital unit, nor to seeing my six feet, 220-pound son looking dazed, in shorts and t-shirt, scabs covering his face and dozens of deep, self-inflicted cuts all over his forearms and thighs. As I held him in my arms I couldn't breathe—thoughts swirled—how much pain must he be feeling to have done this to himself, how long had he been holding that pain in that it had to explode like this, what had I done to cause this, how could I have prevented it? Questions … guilt … helplessness … pain. I felt destroyed … I wanted to scream, to cry. I had entered a totally foreign world and I was terrified—and, worst of all, I knew my terror was nothing as compared to his.

Millions have entered the world of mental illness as I did that day and for far too many, I fear, it remains a strange and alien place that is consistently cold and hostile. That has not been my husband's nor my experience. Our son had the good fortune to receive what we know in retrospect was reasonably good care. And, he had the courage to make the decision not to hide what he was experiencing from his sister and stepbrother or from his larger family, many of whom became sources of comfort and support. And he and his father and I were blessed with the never failing support of our pastor and our church.

Each Sunday, for months, our son was remembered in prayer and although our pastor, who was quite new to our church, had never met our son, he wrote him, he called him, he offered to accompany us on visits to him or to go himself. And because our son's condition was known throughout our church family, one Sunday soon after his hospitalization, a member of our congregation told us about a local support group for families of persons living with mental illness. Later that day she called us with all the details so that we could soon attend a meeting. That support group was the National Alliance on Mental Illness (NAMI) and we credit that group, along with the support we received from our church, with making the first few months after our son's diagnosis bearable for us. It was through NAMI that we came to understand our son's diagnosis—clinical depression so severe he was psychotic, borderline personality disorder, anxiety disorder, and Attention Deficit Disorder (ADD). The NAMI also equipped us with skills we could use in helping him get the treatment he needed and with helping us reclaim our own lives by learning that self-care is an important part of loving and being of help to someone who lives with a mental illness.

I fear, however, that our experiences may be the exception. Because our son was living more than a thousand miles away, it was not always possible for us to give him the kind of assistance he needed. Knowing we were worried about him having dependable transportation to his outpatient program, our pastor called a fellow pastor in a Presbyterian church near where our son was living and asked that he give our son any assistance possible. No contact was ever made. Likewise, when we were with our son we attended yet a different nearby Presbyterian church and I asked, in a written request, that the pastor visit our son. No visit ever occurred. This lack of response was very hurtful to us, because our son needed help and reassurance and we knew of few places to turn to. We had thought we could count on our church wherever it was located to attempt to help us in our time of need, but we were wrong. Fortunately, the compassion we found in our home church kept us believing in the capacity and mission of our church to help those who are hurting. And it has kept us praying that the understanding, the love and the support we found in what was our neediest hour will be present soon in all of our churches for all who live with mental illness and for their families.

The fear and great sadness that my husband and I experienced in the first few days and weeks of our son's illness has abated. We continue to grieve the ways in which his illness limits his options and prevents him from taking full advantage of his many gifts. But this pain is more than offset by thankfulness that he is in recovery and that he has a full life. He has taken many steps forward and, yes, a few backward, but he continues on a path toward increasing wellness and he, his father, and I are filled with hope. Thanks be to God.

A Daughter's Story

I grew up with a mother who had a mental illness. It was never diagnosed. Rather, spiritual language was used to explain the condition. We would refer to her erratic behavior as "the dark night of the soul" or as a "demonic attack." What was predictable was the unpredictable. Many times I went to bed crying because of the verbal attacks, and vindictive God language my mother used as weapons to keep us under wraps. God was not pleased with me. I was going to hell if I did not change my attitude. I was ungrateful and God would never bless me if I had evil thoughts about my mother in my head (which I did, so that sealed it!). I would try hard to please, but it never seemed good enough. If I looked forward to something, and let it matter, the rug would be pulled out from under me. I learned to neutralize events—NOT to let things matter. I said "whatever" a lot and meant it. For instance, we would be packed and ready to go on a vacation that I had been looking forward to for weeks. Then my mother would get a word "from the Lord." It was not God's will that we go on vacation after all. We would unpack and file back into the house, halfway convinced that we had been spared a terrible accident, or some other dreaded happening. I was never fully convinced however, that "mother" was the voice of God. At night when she woke me to cast demons out of me, mumbling incoherently, I wondered whether this is what other mothers did to their daughters. When we spent all Saturday casting evil spirits out of the house—going into every room of a huge four story dwelling—I would wonder whether other families spent their Saturdays doing this sort of thing as well. When she vomited to purge herself, or when she kept to herself for long hours up in her room with the door locked, I had the slim suspicion that perhaps things were not okay.

When I would awake (again in the middle of the night) and hear my parents screaming at each other, slamming doors, and my mother would disappear to an apartment in another city for a month or two at a time, I knew it wasn't all about me. I might have been the most common target for her verbal lambasting but I came to realize that there was more to it all than just me. It was hard to get validation for this gnawing sense of unease and edginess because I was fairly isolated. I wasn't really allowed to have friends. It was always OK at first, but then once they came over my mother became convinced that they brought with them a kind of heavy oppression, and I would have to cut the relationship off. It was easier to just not have any relationships at all.

My father was a kind man—a theologian at a well-known educational institution for higher learning. He kept telling me my mother would get better. After a blow up he would assure me that this was the last and final outrage. Yet, at times, when the chaos and anger got to a tipping point he would shake his head and say "Why does she have to be so cruel to you? She not only sticks the knife in, but then she turns it." I am sure I didn't know why she had to be so cruel, but at least it was validation for my sense that all was not as it should be, and I clung to his words.

Someday I thought to myself, I would show my parents and the world how life was meant to be lived. I would succeed, I would survive, I would be happy. Meanwhile, I tried to accommodate, ameliorate, and adjust my needs so that my mother's needs could be met. All of us, my dad, my sister, and myself danced around the mental illness like marionettes pulled this way and that by erratic, unpredictable, strings of mood and temper, chaos and unpredictability. Jumping here, jerking there, we were caught in the web of dysfunction, and, never able to state the problem, were victimized by it.

Years of intensive psychotherapy later as I look back at the shattered landscape of my past, I am amazed that our spiritual language—instead of freeing us—kept us stuck. We were a Christian family. Mental illness doesn't happen in Christian families! How on earth could we embrace the fact that we weren't perfect, that somehow we were flawed, diseased, wrong headed? That reality was too threatening. Spiritual language glossed over the psychosis and distortion to create a situation where everything wrong, evil, and bizarre was projected out onto the world. It wasn't us who had the problem. It was the world. It was "those people" out there who were tainted, wrongly motivated, unable to cope. We had the truth. It might have been a psychotic episode my mother had just experienced, or a lurking premonition that something "bad" was about to happen. Still, instead of naming it "the problem" we called it "truth" and believed that the lie was our salvation.

Today, I am alive because of the grace of God. I have experienced and know firsthand the love of Jesus, which is nothing like the image of God I was raised with. I have come to know myself, others, and the value of relationships that I long ago was denied. Life is full, God is good, and the freedom to love and be loved, a pure gift.

Each of the stories cited above gives its particular perspective on the devastating effects of serious mental illness on families. Below is further discussion of the experience of (a) parents of children with serious mental illness and (b) parents with mental illness raising children.

1. *Families of People with Serious Mental Illness*

The diagnosis of serious mental illness not only changes the life of the person who is affected, but also the lives of all those who surround him or her. Not only individuals with serious mental illness experience exile, but their families as well. One in four American families has a close relative affected by serious mental illness.[57] The sheer number of persons affected by serious mental illness is staggering and yet it remains "… far from the spotlight of public information."[58]

The 216th General Assembly (2004) of the Presbyterian Church (U.S.A.) affirmed: "We envision a church and society that welcomes and nurtures all persons, regardless of their family circumstances. … We look toward a society in which all members of the family are valued equally, with special attention to children and others who are more vulnerable."[59] Certainly, people with a serious mental illness should be included in that population which is particularly vulnerable. They and their families are rightful claimants to our "special attention."

However, instead of special attention, many persons who are living with mental illness, and their families who live among us and are part of our congregations, receive no attention at all. This neglect may result from a lack of knowledge about mental illness within many churches and an unwillingness to become involved in complex and painful situations.[60] It also results from the reluctance of families, because of the severe stigma attached to mental illness, to admit that a family member has a mental illness. In a 1991 *Church & Society* issue, the Reverend John M. Cannon writes: "Mental illness is one of the least understood of all illnesses. The myths and misconceptions that surround it are numerous and generally prejudicial. … Families are well aware of this stigma and are apprehensive about exposing themselves or their loved ones to it. No one wants one of their family feared or ridiculed, so they are silent."[61]

This forced silence, this inability to share and to talk openly about the illness of a loved one, compounds an abundance of other difficult circumstances and painful emotions. Having an ill family member—a son or daughter, a spouse, a sibling, a parent—is sometimes overwhelmingly painful and all-consuming regardless of whether the family member is in the home, living independently, in a hospital, living in community mental health accommodations or homeless.

For example, unlike parents who have a son or daughter diagnosed with a physical illness, those whose offspring have a mental illness are often overcome with guilt. For too long society placed responsibility for mental illness on parents and their ability to nurture. And even though these theories of poor parenting have been debunked, the stigma persists and adds a sense of blame and shame for parents to shoulder. Therefore, we must continue to work to eliminate the stigma associated with mental illness while at the same time also acknowledging that all forms of child abuse and neglect does affect the development of a child physically, mentally, and spiritually. We cannot condone any form of child abuse or neglect, especially parental child abuse or neglect.

Moreover, having a son or daughter, a spouse, a sibling, or a parent with a serious mental illness is similar to experiencing the death of that person, because in so many significant ways the illness takes away the person one has known. He or she is gone along with the dreams and aspirations for him or her. However, the person has not died, and grief lingers. For months, sometimes for years, families have to endure this grief, often without the love, understanding and support from others. Frequently, the grief is accompanied by a sense of rage and anger. Mental illness seems particularly random in nature; all of its causes are not fully understood; and therefore, any understanding as to why it has happened to a member of one's own family is especially elusive. This combination of profound sadness and anger is a potent emotion, and can be crippling.

There is also a tremendous toll exacted on the entire family by the time and energy spent attempting to care for the person living with serious mental illness. This care requires working with an extremely complex mental health care system that few know about before it is needed, usually under conditions of crisis. Most persons do not know where to turn to get the information they need or the help they require. Many, if not most, families bounce from emergency rooms to physicians to specialists to hospitals to community mental health agencies; an experience that is incredibly time consuming and exhausting. Many times the justice system is involved; and thus additional complications arise. There is also, more often than not, constant worry about how to meet the cost of all the services needed when insurance is absent or inadequate, and how to plan for a time when there may be no one left in the family to care for the ill member.

Frequently, the ill person requires round-the-clock supervision and assistance with medications and accompanying side-effects, constant vigilance to recognize signs of impending problems and crises; and if the potential for violence is present, particularly careful vigilance. Nearly unbearable levels of stress can burden the family members of the person with mental illness. One can reasonably say that having a person with mental illness in one's family and home can be totally consuming, leaving little if any time for the needs of any and all other family members. This demand on time and energy, coupled with the unpredictable course of the illness and the constant presence of stigma, make "normal" life—friends, social occasions, the activities of other family members, community concerns, congregational life—very difficult. These sacrifices are particularly burdensome to children and young adults who are sometimes required to be caregivers for parents with serious mental illness.

One father writes about his son's illness in the following way: "I thought that I knew all about illnesses. After all, I had survived a life-threatening car accident, bleeding ulcers, our daughter's juvenile diabetes, and a bout with cancer. But I knew nothing of illness until I confronted schizophrenia. It is like no other illness I have encountered."[62] Likewise, a man describing his wife's illness confesses, "… when it brings a loved one to visible alteration of thought processes and behavior, [it] is the most frightening thing I have experienced in a background that includes some of the experiences, like war, that are reckoned most stressful. To see the loved one out of control … to watch such behavior and be unable to help is desolation of a special kind for a life partner to endure."[63] The Reverend John Cannon supports these statements, writing, "family life be-

comes unsettled … needs of other family members and management of the usual tensions that arise in everyday living … must be done in a climate filled with bewilderment, embarrassment, and secrecy. Living with a mentally ill loved one is exhausting emotionally to every member of the family. It can and in some cases does destroy a family."[64]

A mentally ill person's awareness of the impact of his or her illness on family members must not go unnoted. A person suffering from mental illness often acknowledges the adverse effects of the effect of his or her illness on parents, partners, siblings and, in some cases, an offspring. Their sense of responsibility for the perceived damage their illness does to the family increases the burden of the illness and further complicates the recovery process. Consequently, caring for the families of those with mental illness and helping to relieve their burdens not only strengthens them, but also helps to bring healing to the family member who is ill.

Through its approval of the *Resolution on the Church and Serious Mental Illness*, the 200th General Assembly (1988) recognized its vital role in lessening the pain and suffering of families of the mentally ill, saying, "Reclaiming health as a central dimension of the church's faith and life is of particular importance as the church seeks to meet persons and families struggling to cope with mental illness."[65]

2. *Parents with Mental Illness Raising Children*

Parents with serious mental illness are at risk of losing custody of their children if their symptoms are not well managed and affect their parenting skills. Although the diagnosis of a mental illness is not a sufficient reason to lose custody, mental illness can make it more difficult for parents to care for their children competently. Although the parents who have mental illness may be caring and loving, they may be forced to give up custody of their children when their condition worsens. During acute phases of their mental disorder, parents may have trouble caring adequately for their children and face forced intervention by child welfare authorities. While it is imperative to ensure the safety and welfare of each child, it is highly traumatic for both parents and children to face this possibility. The trauma of losing custody adds another layer of suffering, which complicates recovery. Loss of hope, guilt and shame, alienation from the social service system, and added stigma increase the burden of already troubled individuals. Parents now have to navigate the maze of child protective services and the courts. Supervised visitations are intrusive, regular visitations burdensome, and evaluations threatening. They can feel betrayed by mental health professionals who are required to report abusive situations, and they feel hurt when their children exhibit mixed loyalties between themselves and their court-appointed guardians. This is especially true when children are placed with family members, who may already be in conflict with the parent.

Unfortunately, due to fear of custody loss and these other complications, parents exhibiting an exacerbation of their symptoms may avoid contacting health care professionals. This avoidance can make matters worse, as delay can worsen an already deteriorating situation, making it more likely that they would indeed lose custody. Clergy and other church caregivers can be good avenues of help because parents may feel safer coming to them rather than mental health professionals. This first line of response may be adequate to help stabilize their condition. If it is not, the church caregiver may then have to notify child protective services. Although this may feel to be a gross breach of trust, the child's welfare is primary. When handled well, a favorable outcome can be achieved. For example, the family may be placed in contact with much needed community services for both parents and children. To help sustain trust in the church caregiver, it is of utmost importance for the caregiver to provide close follow-up once a call to protective services is made. If legal matters arise, the help of an attorney who specializes in this area can be solicited.

In 1997, the federal government passed the Adoption and Safe Families Act to protect ill parents from losing their custody rights. When parents do lose custody, appropriate treatment and support must be given to the parent so that family reunification can take place. Churches can assist parents who lose custody of their children by becoming familiar with such protections and referring parents to good legal counsel.

Many families find themselves in a no-win cycle of loss. Mentally ill parents fear that seeking help will lead to their losing custody of their children. Therefore they do not seek the psychiatric services they need and their parenting ability is further diminished.

E. *Twice Exiled: Serious Mental Illness and Disaster Response*

While natural disasters and warfare have always been with us, in the past decade we have experienced these events with greater awareness of the impact of these events on persons with serious mental illness and our national response patterns. With the major terrorist activity on U.S. soil on September 11, 2001, the effects of war in Vietnam and Iraq, and the aftermath of recent hard-hitting natural disasters, we have become more aware of weaknesses in our responses to and treatment of persons with serious mental illness. Emergency shelter settings are poorly equipped to recognize the difference between behaviors triggered by substance abuse and persons with serious mental illness. In the midst of the crisis response, there needs to be available interventions, both to those in crises and to the responders.

Tom's Story

During the disaster response of Hurricane Katrina in 2005, Tom, a young man in his late twenties, showed up at a local shelter in Louisiana. Because of his bizarre behavior, he was turned away by security who assumed that he was on drugs. Since this shelter was in a local community recreation building, Tom wandered across the street to the curb in front of a neighboring home. The family found him sitting there and after talking with him brought him back to the shelter. Security called the mental health volunteer from Red Cross who discovered that Tom had been on medication, which he had lost in the storm. A trip to the local hospital got some emergency medication and confirmed the diagnosis of schizophrenia. However there were no available beds. The on-call physician claimed that the only resource was the local jail. Therefore, we returned Tom to the shelter.

Although it was nearly midnight, many folks were still up. A small circle of affirming individuals helped Tom to calm down and feel safe. Within the next few days, Tom felt safe to share with others his history of mental illness, his struggle with homelessness, several failed efforts at employment, brief hospitalizations, and even two incarcerations for petty theft done at the bidding of other people who took advantage of his vulnerability. A local pastor was contacted whose congregation took an interest in befriending Tom and helping him seek more appropriate alternatives to jail and homelessness.

God's call for compassion used a variety of persons who went beyond their usual comfort zone and responded to this opportunity for ministry. The culture of the emergency shelter and this congregation was dramatically altered as they focused their passion and compassion with one otherwise homeless person with a serious mental illness.

F. *Driven into Exile by Chronic, Extreme Stress: The Examples of Poverty and War*

When disaster strikes, people who already live with serious mental illness often suffer more than people without. In addition, there is also ample evidence that chronically stressful life circumstances can result in more people developing a mental illness. Considering all mental illnesses, not just serious ones, a large study of more than 100,000 people shows that the poor are more vulnerable. Socioeconomic status affects "the development of mental illness directly, as well as indirectly through its association with adverse, economically stressful conditions among lower income groups."[66] The extreme stress of war also has negative effects on mental health. *Time* magazine reports, "about one third of the 103,788 returning veterans seen at Veterans Administration facilities between September 30, 2001, and September 30, 2005, were diagnosed with mental illness or a psycho-social disorder—such as homelessness and marital problems, including domestic violence."[67] Of this group, 56 percent had two or more diagnosed mental illnesses.[68] The same study shows that 13 percent of those returning veterans were diagnosed with Post-Traumatic Stress Disorder (PTSD), approximately the same proportion as veterans returning from the Vietnam War. However, young soldiers who had been on active duty in Iraq were three times as likely to be diagnosed with PTSD as those over forty.[69] While PTSD falls outside the definition of serious mental illness as defined in this paper, these findings establish the link between a stressful context and mental illness.

Research that focuses on the relationship between serious mental illness and the stress of a lower socioeconomic status is more challenging. It is more difficult to determine whether poverty is the result or the cause of all serious mental illnesses. However, research does show clearly that depression and a lower socioeconomic status are clearly associated.[70] Furthermore, the impact begins in the early years. "Low-childhood socio-economic status is associated with a higher lifetime risk of depression."[71] There is also a higher risk for schizophrenia when born into a poor family.[72] However, lower socioeconomic status and serious mental illness cannot always be correlated; there is also evidence that higher social class may be associated with increased risk for bipolar disorder.[73] Much research remains to be done to clarify the complex relationship between socio-economic status and serious mental illness.

G. *Violence In Exile*[74]

Perhaps the most damaging myth about people with serious mental illness is that they are dangerous, that their behavior can turn violent at any moment. Perhaps this widespread belief is chiefly responsible for their being exiled from the covenant community. Many people come to church seeking safety and comfort, and the presence of someone with a serious mental illness may threaten their sense of security. Yet, "the vast majority of people with mental illnesses are not violent," according to the National Mental Health Association (NMHA).[75] "In the cases when violence does occur, the NMHA continues, the incidence typically results from the same reasons as with the general public, such as when one feels threatened, or uses alcohol and/or drugs excessively."[76]

It is true that some persons suffering an acute episode of psychosis sometimes do become violent. In such cases churches are responsible for protecting those who might be vulnerable. Family members are at greatest risk for violence at the hand of someone with a serious mental illness.[77] Since the potential for violence may exist, it is important that churches develop and implement a plan for maintaining a safe environment. For congregations who are called to reach out to people whose psychotic symptoms may lead them to acts of violence, mental health professionals can provide advice for churches that wish to

create times and places where the possibility of violence is minimized. These churches can have safety plans in place should they be needed.

Bill's Story

Bill is a forty-one year old male who appears in the church garden one day. He tells ladies working there that he has made and sold cakes before, and they invite him to worship. He soon becomes a regular attender, and finally joins the congregation.

The pastor learns that Bill once served ten years in prison for robbery, petty crimes, and gang-related activity and is now on parole. He is known at the local outpatient mental hygiene clinic, where he has been diagnosed schizophrenic. He is being seen by a psychiatrist for medication, monitoring, and weekly psychotherapy. In addition to having schizophrenia, Bill is considered to have a character disorder, i.e., a psycho-pathology (personality problems which might prove harmful to other people). However, in the congregation Bill continues to be very polite, courteous, outgoing; and members seem to accept him. They encourage him in his cake baking and open the church to his family when an older brother dies. Later, the pastor encourages him to serve as a chaperone/bouncer for the Friday night teenage group.

During this time, however, Bill does not adhere to his medication regimen, and misses appointments with his therapist and parole officer. He gives out misinformation, uses illegal drugs, and becomes homeless when he can no longer live with his mother. Eventually his therapist and his case manager find a single room where he can lodge. The pastor learns of this turn of events from Bill, but most members of the congregation continue to have a completely different view of Bill. They consider him a "nice young man." For he is indeed charming, pleasant, congenial, and engaging.

After a while Bill returns to prison, and some church members learn the truth of Bill's life. The pastor and another church member are concerned about Bill, but he remains a model church member. Church involvement obviously was providing for Bill some of the love and affirmation that a family ordinarily would. Church had proven to be a stabilizing force in his life. The pastor and the personnel chairperson in whom the pastor confided remain concerned about the possibility that harmful aspects of Bill's personality might emerge in church.

How should Christians balance the moral duty to take some risks to help persons with mental illness over against the obligation to protect others whom they might harm?

Sometimes moral responsibility requires choosing not between a good thing and a bad thing, but between two goods that are in tension, as in this instance. How were the church leaders to balance the good of fully including persons with serious mental illness within the congregation over against the other good of protecting congregation members from possible harm? Sometimes achieving one good may require compromising, at least to some degree, another. The recent killings at one university are another case in point. The killer had a record of serious mental illness, but laws protecting the privacy of his medical information hindered it from being shared in a way that might have prevented the tragedy. In that instance, the values of communal security and individual privacy were in tension. When goods are in tension like this, we should strive to preserve as much of each as possible, instead of sacrificing one entirely to achieve the other.

Of course, the greater risk is that people with serious mental illness will be victims of violence themselves. Life in prison or on the streets makes them vulnerable to physical violence. Within families, they can also be victims of domestic violence, which includes both physical and emotional abuse. Not only are they at risk of being hit, punched, or kicked, but also being ridiculed, humiliated, and insulted. Some believe it is acceptable to sexually abuse people with serious mental illness. Again, congregations have a responsibility to protect people with serious mental illness from violence and abuse of any kind. This may require partnership with mental health providers, social services, lawyers, or the police.

H. *Specific Peoples, Specific Exiles*

Serious mental illness is closely linked to particular contexts. The impact of age, race, ethnicity, gender, acculturation stressors, and place of residence all affect the shape of the experience of serious mental illness. For that reason, we can say there is no one landscape of the exilic experience.

1. *Children and Youth*

Just as adults suffer from serious mental illnesses such as depression, bipolar disorder, and schizophrenia, so too do children. Children also have mental illnesses such as autism, Asperger's syndrome (AS), severe Attention Deficit Hyperactivity Disorder (ADHD), and reactive attachment disorder that severely disrupt basic life functions of living in a family, community, and a school. Clergy and church staff are in a unique position to help identify children at risk for mental illness, because they are often the first responders to crises, and they become involved in the lives of families in ways that other professionals do not. Identifying children and adolescents who are at risk or who have a mental illness is difficult, as the boundaries be-

tween normal and abnormal behavior are less defined in children than in adults. Further, normal behavior for children is age dependent. For instance, what is appropriate for a six-year-old may be inappropriate for a twelve-year-old. Identifying children who are having difficulties is often perceived as helpful, but it could also be seen as intrusive and stigmatizing.

When identifying children at risk, one needs to consider the circumstances of their development. For instance, children who experience disruptions in the family system, such as a death, exposure to trauma, a marital break-up, domestic violence, or acculturation stresses, are psychologically at risk. Behaviors that are associated with mental illness include isolation, excessive fears or worrying, physical complaints, school avoidance, changes in academic performance, and persistent sadness or rapid changes in mood. They also include oppositional behavior, inattention, impulsivity, difficulties with language, stereotypical or repetitive behavior, having a lack of social cues, literal thinking or confused thinking, and changes in one's peer group.

Because federal law requires that all students receive equal access to a public education, special attention must be given to children with educational disabilities. Schools are required to provide services to help each child compensate for disability so that each has a fair footing with other children. Such fairness is mandated by the Fourteenth Amendment to the Constitution, the Civil Rights Act of 1964, and the Individuals with Disabilities Education Act (IDEA) and its recent revisions.[78] Special education requirements pertain not only to children with learning disabilities, but also to those with mental conditions that impede their education. Major psychiatric illnesses such as major depression or bipolar disorder are covered, as well as less severe conditions.

The IDEA requires that treatment services be provided free to all families without regard to the level of their income. Such services can be delivered both in the school and at home. Services may include individual and family therapy, receiving guidance from an in-home behavioral specialist, respite care, and residential placement.

Unfortunately, many children eligible for such services are often overlooked or underserved. Sometimes eligible children are shortchanged because of governmental budget restraints. Although the IDEA requires schools to search out children in need, parents already have to advocate vigorously to get their children the help they need.

The No Child Left Behind Act of 2001 has generally made life harder for children with special educational needs. This is so because the No Child Left Behind legislation evaluates schools by how well all of their students do on standardized tests. Children in special education, children who speak English as a second language, and children from low-income families tend to bring down these scores.

Parents whose children have mental illness sometimes must contend with school staff and other parents who are ill-informed, resistant, and hostile. They may hold parents responsible for their children's odd or disruptive behaviors because they assume these ensue from poor parenting, not brain-based physiological diseases. Parents whose children suffer from mental illness often worry too that they will lose custody of them, or that they will lose their legal right to superintend their education. Ironically, special education programs guard against parents losing this right by putting them in charge of mandated educational teams. Custody of their children may have to be relinquished occasionally for parents to obtain residential health care for their children in some states. There is a critical shortage of child and adolescent psychiatric care and in-patient beds throughout the country.

2. *Rural Populations*

"Urban culture and its approach to delivering mental health services dominate mental health services. … Rural America is shrinking in size and political influence. … As a consequence, rural mental health services do not figure prominently in mental health policy," according to *Mental Health: A Report of the Surgeon General* (1999).[79]

This failure to understand and address the needs unique to rural populations has led to a vast number of persons with mental illness going untreated. Even when rural residents are able to procure treatment, they "enter care later in the course of their disease than their urban peers, enter care with more serious, persistent, and disabling symptoms, and require more expensive and intensive treatment response. For rural racial and ethnic minorities these problems are compounded by their minority status and the dearth of culturally competent or bilingual providers in medically under served areas."[80] Succinctly put, many rural Americans have inadequate access to care, and they face a shortage of highly trained care providers—85 percent of the 1,669 federally designated mental health professional shortage areas are in rural America. They must cope with lower incomes, and they are surrounded by a culture where the stigma associated with mental illness is entrenched and pervasive.[81] Fewer rural people have health insurance that covers mental illness than do urban residents. They also spend longer periods without insurance coverage, and they are far more reluctant than their urban counterparts to incur medical bills, including those for prescription drugs.[82]

Seeking help is a difficult step for many rural residents to take and it is nearly impossible to do so confidentially in small, rural communities. Stigma is particularly strong in rural settings. When it is coupled with a long tradition of self-sufficiency,

it is difficult to bring issues surrounding mental illness into the public arena. In addition, this fear of stigma and desire for privacy adds to the isolation of those who are ill and their families and, in part, may explain why the suicide rate among rural men is significantly higher than in urban areas and why the suicide rate among rural women is approaching that of rural men.[83] Furthermore, the suicide rate for farmers and ranchers is usually twice the national population average. Given this pattern and the magnitude of the farm crisis in the past three or so decades, it is easy to understand why some call suicide "the most devastating mental health issue found in rural communities."[84]

Because 45 percent of Presbyterian congregations are in rural areas, the mental health needs of rural communities and the scarcity of mental health resources in those communities should be a concern of all Presbyterians.[85] In the policy statement adopted by the 200th General Assembly (1988), *Life Abundant: Values, Choices and Health Care*, all members of the church are called to remember that, "Health and healing are central dimensions of the faith we profess. We must reclaim the power and promise of God's gifts of wholeness for our life … Our understanding of ourselves and God is mirrored by the way we do or do not seek health and wholeness for ourselves, our communities and the world."[86]

3. *Veterans and Serious Mental Illness*

In most congregations, there will be a percentage of veterans or families of veterans. This places the church in an optimal position to identify veterans with severe mental illness and the opportunity to make appropriate referral. This population group transcends race, ethnicity, gender, and age.

Veterans have a high incident rate of PTSD, paranoid schizophrenia, and bipolar disorder, which may contribute to substance abuse and homelessness. In addition, the suicide rate is three times the general population. According to NAMI, "nearly one third of homeless persons are veterans … approximately 43% of homeless veterans have a diagnosis of severe and persistent mental illness, and 69% have a substance abuse disorder."[87] Some have estimated that 15,000 (or more) Vietnam veterans have committed suicide since returning home.[88] After being released from jail or prison, "67 % of Vietnam veterans diagnosed with PTSD received their diagnosis."[89]

Seeking help is difficult for veterans. They have been instilled with a "can do" attitude and fear the stigma of appearing weak to their peers. Fortunately, there are many resources to assist veterans. Unfortunately, many churches are unaware of them. Veteran Administration Hospitals can channel veterans into the proper area for treatment. When there are financial concerns, the Veterans Benefits Administration (VBA) office can assist in explaining what benefits are available. In addition, such volunteer service organizations such as the Veterans of Foreign Wars (VFW), Disabled American Veterans (DAV) and the Military Order of the Purple Heart (MOPH), will advocate for the veteran individually and politically.

4. *Genders and Serious Mental Illness*

Gender matters in mental illness. For example, there are twice as many women diagnosed with depression than there are men.[90] Men experience the onset of schizophrenia earlier in life than women.[91] Men with bipolar disorder abuse drugs and alcohol at greater rates than women. Researchers believe that a complicated interaction between biological and psychosocial factors determines such differences.

It is clear that the disparity in access to social power renders women more vulnerable to some mental illnesses. "Gender is a critical determinant of mental health and mental illness,"[92] states the World Health Organization. "Gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks."[93] For example, the physical, mental, and sexual abuse of women and girls render them more vulnerable to depression, one study showing that over half of depressed women are survivors of domestic violence.[94] Therefore, advocacy for the rights of women and girls is a step toward improving their mental health.

While some claim issues related to women's reproductive capacity are related to differences in mental illness incidence, it remains unclear how physiological differences between men and women affect the disparities between their vulnerability to and experience of serious mental illness. Regardless of how mental illness is manifest in males and females, the church should strive to give comfort and support as wisely and ably as possible, to both women and men, girls and boys.

5. *Race and Serious Mental Illness*

Concerted and continued efforts to promote greater access and culturally responsive mental health services are critical for racial and ethnic groups. Race and ethnicity in addition to other cultural diversity considerations like language, gender, geographic location, and physical ability affect mental health and care. Addressing mental health challenges is influenced by how individuals from various groups understand and make sense of their social world.[95] In addition, individuals classified in the lowest socioeconomic income level, education, and occupation categories are about two to three times more likely than those in the highest stratum to have a mental disorder.[96] Many of these individuals identify as racial and ethnic people. Cul-

turally proficient delivery of mental health services takes into account social risk and cultural factors, incorporating these considerations in assessment, diagnosis, and analyses of the mental health of racial and ethnic group members.[97] More research is necessary in order to clarify the role that social and cultural factors have had and continue to have in the mental health of racial and ethnic populations in the United States. The following paragraphs contain data about specific racial and ethnic populations.

a. *Asian Americans/Pacific Islanders*

Asian Americans/Pacific Islanders are one of the fastest growing racial and ethnic groups in the United States. The Asian American population alone was about 3 percent of the total population in the United States in 2000.[98] Understanding the cultural differences that exists within this growing population is important for the purposes of planning appropriate mental health care services.[99] However, research studies conducted with Asian refugees and immigrant populations have revealed that the portion of this population most acculturated to the U.S. culture more frequently shows western types of disorders.[100]

b. *Black/African Americans*

According to the 2000 United States Census Bureau, 12.9 percent of the total United States population identified themselves as Black/African Americans.[101] This group of Americans is ethnically diverse; and its size and ethnic diversity is increasing as more immigrants arrive from the continent of Africa and Caribbean Islands.[102]

From a historical point of view, living in the United States has been particularly stressful for most Black/African Americans, who have experienced egregious social prejudice and segregation perpetuated by negative attitudes and beliefs related to racial and ethnic group membership. Today, many Black/African Americans still experience a variety of health challenges, and bear a disproportionate burden of mental health problems related to historical and present day life experiences. In addition, some research has revealed gender differences in rates of mental illness for Black/African Americans. For example, the prevalence rates of depression, phobias, and anxiety disorders are higher among Black/African American women than Black/African American men. Black/African American women reported higher incidents of medical, psychiatric, family-social, and employment problems than did Black/African American men. Black/African American men reported higher incidents of legal and alcohol-related problems than did Black/African American women.[103] However, the higher incidents reported by Black/African American men may be attributed in some cases to self-destructive mental disorder behaviors such as alcoholism, drug abuse, and criminal activities that increase the probability of their encounter with law enforcement and the judicial system.[104]

c. *Hispanic/Latino/a Americans*

Hispanic/Latino/a Americans represented about 12.5 percent of the total United States population in the year 2000.[105] Like most of the other racial and ethnic groups living in the United States, Hispanic/Latino/a Americans do not always receive the quality health care services they need. Language barriers often limit this group's ability to utilize major mental health services. In addition, increasing evidence suggests that Hispanic/Latino/a Americans are less likely to receive evidence-based care in accordance with professional treatment guidelines in clinical settings in the United States.[106] However, there are social and cultural patterns that can promote mental health within the Hispanic/Latino/a community (i.e., the value of families, which provide support and act as a preventive factor for serious mental illness).

d. *Native Americans/Alaskan Natives*

Comprising 0.9 percent of the U.S. population, many Native Americans/Alaskan Natives suffer an unequal burden of mental health problems as compared to white Americans.[107] In addition, some Native Americans/Alaskan Natives suffer from considerable health disparities as compared with the general United States population, including drastically higher incidence and prevalence of preventable diseases such as diabetes, substance abuse disorders, particularly alcoholism, and complications. The under funding of health-care programs, such as the Indian Health Service, and socioeconomic factors have contributed to the health disparities cited above among Native Americans/Alaskan Natives.[108] There is an extreme demand for culturally sensitive health-care programs and providers that can address this group's physical and mental health care needs.

In summary, Native Americans/Alaskan Natives, Hispanic/Latino/a Americans, Black/African Americans, Asian American/ Pacific Islanders, and Middle Eastern Americans are more likely to experience inadequate mental health services due to social, cultural, and economic issues. Not only do biological, spiritual/religious and psychological factors affect the incidence and prevalence of one's mental illness, social conditions such as poverty, unemployment, and racial and ethnic oppression and discrimination inform whether individuals will seek mental health services and the availability and quality of services received.

6. *Pastors and Seminarians*

Through the committee on preparation for ministry (CPM), the *Book of Order* directs presbyteries to become acquainted with candidates for ministry specifically (G-14.0305). In order to fulfill this mandate, presbyteries should offer education for sessions, congregations, and ministers about serious mental illness, and support when necessary. This mandate to maintain these "ongoing relationships takes seriously the unique background, experience, and personal attributes of each candidate for pastoral ministry."[109]

For ministers just beginning their pastoral work, their first call is a time both of challenge and stress, "a time when one can benefit greatly from the continuing, planned support of one's congregation and presbytery."[110] For pastors with a serious mental illness, stress can reveal needs that are not always apparent at first, nor well understood. Presbytery staff who are well-equipped to pastor to pastors are crucial for the health of every minister, but particularly for pastors who have a mental illness. Pastors who face mental illness should be encouraged that such illness, when adequately addressed, can enhance their ministerial effectiveness. The 2006 *Presbyterian Panel Survey on Mental Illness* revealed that 50 percent of pastors who reported having mental illness indicated that they were more empathic and compassionate to those with burdens, and more knowledgeable about mental illness and treatment options. This was in contrast to only a small portion (7 percent) who responded that having mental illness negatively affected their ministry.[111]

The 200th General Assembly (1988) noted: "All the people and structures of the Presbyterian Church (U.S.A.) are called to ministry and mission with those afflicted with serious mental illness. … In fulfilling this ministry and mission, the church at all levels should … support increased understanding and the development and training of leadership … through education and training in seminaries, consultations and network-building at national and regional levels, through workshops and continuing education events, and through intentional use of church periodicals and both regular and special educational resources."[112] Pastors and seminarians should be included in the church's care for people with mental illness.

Although the church calls pastors to minister to persons with serious mental illness, results from the 2006 *Presbyterian Panel Survey on Mental Illness* indicate that seminaries do not adequately equip pastors in this respect.[113] For example, a large majority of pastors responded that their seminary training equipped them "not too well" or "not well at all" in:

- developing church programs for people with mental illness (92 percent of respondents);
- providing therapy (77 percent of respondents);
- understanding mental illness (67 percent of respondents);
- relating to those with a mental illness (61 percent of respondents); and
- recognizing and making an appropriate referral (53 percent of respondents).

The survey also shows that seminaries often do not adequately train future pastors to handle crisis situations. This finding is a serious concern because pastors are often first responders in crises. Slightly more than 60 percent of clergy respondents indicated that their seminary training prepared them poorly to respond to trauma, child abuse, and domestic violence. Almost half indicated they were not well-equipped to respond appropriately to suicidal or homicidal persons.

One way for church members' needs to be addressed is for seminaries to require that students study mental health, and in their fieldwork interact with people with mental illness, and their families. Seminaries have already been encouraged "to consider expanding opportunities for such learning in M.Div., D.Min., and continuing education programs."[114] These programs would greatly benefit not only seminarians but pastors as well.

It is important for pastors to identify a referral network when first arriving at a new call. Referring a church member to a mental health professional is not a substitute for rendering good pastoral care; rather it may be the most effective way to do so. Ongoing relationships and ongoing education between the pastor-seminarian and presbyteries, committees and schools to which they relate, is an essential component in addressing the issue of serious mental illness in the church.

V. God's Call to Comfort

Come to me, all you that are weary and are carrying heavy burdens, and I will give you rest. (Matt.11:28, NRSV)

For many who live with serious mental illness, life in exile can include homelessness, addiction, suicidal thoughts, discrimination, families in pain, violence, and barriers to employment and mental health services, as outlined above. These aspects of exile are shaped by gender, race, and age, and are especially challenging for people seeking ordination or who are already ordained. Yet God does not abandon us, God is with us still. We can proclaim to people living with serious mental illness the words of the prophet Isaiah, "The people who walked in darkness have seen a great light; those who lived in a land

of deep darkness—on them light has shined" (Isa. 9:2, NRSV). Many congregations have found fruitful and faithful ways to respond in ministry to people with serious mental illness.

A. *Many Congregational Responses*

When the church welcomes individuals who have been in exile, the church itself moves closer to the covenant community we are called to be. As we offer comfort, we ourselves move closer to God. By the grace of God, churches have responded to God's call to comfort the exiles in many different ways. In so doing, they are extending Jesus' invitation to the weary and heavily laden to come to him for comfort and rest.

Results from the 2006 *Presbyterian Panel Survey on Mental Illness* indicate that about half of lay respondents and most ministers would like their congregations to do more to welcome people with mental illness.[115] Approximately 80 percent responded that people with serious mental illness "have gifts to bring to the church." Yet, although there is clearly an interest in ministering to and with people with serious mental illness within the church, this interest is not acted upon very often. For example, only 16 percent of elders stated that their congregation provided space for a support group for people living with mental illness. Even less, 7 percent of elders, report that their churches are providing space for support groups for family members or caregivers of people with mental illness. Furthermore, 7 percent or less stated that they had heard a sermon about mental illness; 10 percent had held a prayer or healing service for people with mental illness; and 5 percent had a class on the topic. Even more disconcerting, only 4 percent stated that their congregations advocated for public policy on behalf of those with mental illness.[116] In contrast, there is a keen interest, especially voiced by pastors and family members of people with mental illness, to obtaining resources to help them minister in this area. Such resources include guides for ministry with people who have a mental illness, for conducting Bible studies on mental illness, and for setting up support groups.[117]

Although services currently provided by congregations to persons with serious mental illness are insufficient, the members of the Task Force on Serious Mental Illness met with members of several PC(USA) churches that are ministering in exemplary ways. The following paragraphs describe these ways.

1. *Hospitality*

In many instances, churches said that they did not have a program in mind when they first got involved in ministry with persons with serious mental illness. They simply wanted to be hospitable. They felt compassion for people who were hungering for acceptance and fellowship; and so, they began to eat with them, go to a movie with them, or bowling. Camaraderie paved the way for these new friends to attend church. As more and more people with serious mental illness attended, the next step in hospitality was for a congregation to change some of the ways that it worshiped, in order to make the newcomers more welcome

Some congregations expressed hospitality with no particular emphasis on the uniqueness of people with serious mental illness—they were simply folded into the life of the congregation without special attention to their illness. Other churches articulated their special commitment to hospitality for people with serious mental illness. Still others created specific programs such as support groups or special classes for people living with serious mental illness and their families. All of these have been found to be equally faithful ways to show hospitality.

2. *Prayer-based Support Groups*

One notable form of hospitality is providing spiritual support groups based on prayer. Such groups recognize the genetic, biological, and social aspects of mental illness, yet keep their focus on the redemptive and restorative work of Christ to help people heal from life's wounds. While many different kinds of groups can help people with mental illness, prayer groups offer a spiritual balm that others cannot provide. Prayer groups include a time for sharing in confidence and a time for praying for each other. Through these gatherings many have found healing for body, soul, and spirit. Prayer groups enable the church to proclaim hope for the despondent, clarity for the confused, and a peace that passes understanding, all through the power of the living God.

Fred's Story

Twenty-three years ago our son, Andy, was well into his college training to be a missionary aviator. At age twenty-one he had his first major episode of bipolar disorder. It was very traumatic for our whole family. He quite quickly became very paranoid, delusional, and hallucinatory. We went to our pastor for support. He said, "Well, that's the end of his missionary career" and didn't even offer to pray with us. We badly needed support and understanding, but we did not find it then in our church.

This ultimately led Jane and me to a different church where we became involved with its mental illness support ministry, which was just beginning. In the past six years that ministry has grown and developed in unbelievable ways. We feel that this growth has been the result of much prayer.

For the first two and a half years the support group consisted of just persons in caregiving roles. However, when two of these caregivers disclosed that they had a mental illness themselves, we decided to invite those coping with a mental illness, "copers," to become members of our group. With the addition of "copers," our support group took off, both in vitality and numbers! The sharing and prayer times became a real blessing to both copers and supporters. More than an hour of each meeting was devoted to prayer with a person who had shared. We continue to have both Christians and non-Christians in our group. In times of great need people are most open to the gospel message that the love of Jesus saves.

Our blessing comes from having a large number of wonderful copers in our fellowship. We found that a large percentage of our copers maintain control over their behavior with medication. They are sensitive and articulate.

We also learned quite early that a coper's biggest need is to have a friend, and then, to have a fellowship that is understanding, caring, loving, and supportive, and one where it is safe to be honest, and where one feels valued, and accepted as a first class member.

We were led to meet every Thursday night, and to provide our own simple dinner, which adds additional time of relaxed fellowship. Our worship time includes a short devotional led by a coper. A guitarist leads us in singing a couple hymns or praise songs. Our current attendance runs about twenty-five.

One of the reasons that our meetings run smoothly is that we read our guidelines in unison. Those guidelines commit us to confidentiality, not dominating in the sharing time, not interrupting, and not giving advice. Also, we commit to being available to each other for praying.

We call our group H.E.L.P., which stands for Hope, Encouragement, Love, and Prayer. People affected by mental illness can be helped in their recovery by: developing faith in a loving God; hoping for improvement; praying for guidance; living in a community of acceptance, love, and encouragement; and knowing that others care, that we all count and have a purpose in life to carry out.

3. *Education*

Some churches have been inspired to be involved in ministry with persons with serious mental illness through sermons, Bible studies, or Sunday school discussions. Their pastors and teachers have informed them of various kinds of mental illness, and related this psychological information to biblical mandates for compassion, tolerance, and justice. This education encouraged many people to share stories of their own experience of mental illness, or that of loved ones or friends. Education sometimes moved church members to become activists, reformers in the field of mental health, because it awakened them to how widespread mental illness is. They began to see that they would have allies in this ministry, and experienced new enthusiasm for it.

In this sense, education is a transforming experience. It involves the transformation of the stranger with serious mental illness into a neighbor, a friend, a sister, a brother, a member of the Body of Christ. Education is much more than the transfer of information; it is rather an invitation to a relationship with someone with a serious mental illness. It is an experience of the scales falling from our eyes so that we see the full humanity of all who live with serious mental illness. (Acts 9:18) In fact, according to an analysis of the *2006 Presbyterian Panel Survey on Mental Illness* results, those who were educated regarding serious mental illness were more willing to personally relate to them.

4. *Providing Services*

Some congregations have been engaged in direct delivery of basic services for people with mental illness. Churches serve meals to the hungry, provide shelter for the homeless, house clinics for health-care delivery, and offer church-based counseling services staffed by mental health clinicians. Some provide space in their buildings for support groups or recreational activities for people with mental illness. Such direct services are a vital link to God's comfort for many who live with mental illness every day. Not only do they provide specific forms of care, but they do so in the name of Christ, and thus offer a sign of his resurrection power to those in pain.

5. *Collaboration and Advocacy*

Many Christians find that the more deeply they are involved in relationships with the dispossessed, the outcasts, the invisibles of any locale, the more they realize that there are systemic reasons for their plight. People with serious mental illness struggle not only with their various symptoms; they also struggle with judicial, criminal justice, social service, and health-

care systems that make it much more difficult to get their needs met. Church members who persist in ministry with persons with serious mental illness are likely therefore to act in the role of advocate, and do so in collaboration with citizens outside their circle of faith who are trying to move social systems toward more effective caring. Hospitality the deeper it goes leads to solidarity with those who are advocating for badly needed reform.

Churches can collaborate with other advocacy and service delivery groups in at least two ways. First, churches can make sure that people with serious mental illness receive what the law entitles them to, such as Social Security checks, and low-income housing. Secondly, churches can work with groups advocating changes in public policy in such areas as insurance parity and alternatives to incarceration. Several groups who met with the Task Force on Serious Mental Illness emphasized the importance of forming coalitions with them in their advocacy work. (Refer to Appendix C for Models of Ministry.)

B. *A Ministry Both Challenging and Rewarding*

1. *Patience and Perseverance*

Many people with serious mental illness who attend church elect not to disclose their illness. They participate in church life without any church members knowing of their illness. When a church welcomes persons who struggle more openly with a serious mental illness and whose symptoms may be more apparent, there will be both blessings and difficulties. Persons with cognitive and emotional problems can be trying. For example, a Bible class that feels held back by a member who almost continually complains about his inadequacies must learn to consider their relationship with him or her just as important as the chapter they are attempting to cover. At the same time, some people with mental illness can benefit from loving and constructive feedback regarding appropriate group behavior. Churches have often found that the gospel of Jesus Christ becomes less doctrinal and more incarnational as they persevere in the deeply compassionate way of their Lord.

2. *Mixed Feelings*

While church members often have positive feelings when they get involved in ministry with people with serious mental illness, they may have negative ones too; and sometimes they deny the negative ones. Denial is likely to weaken ministries for people living with serious mental illness. Tasks first undertaken with alacrity and enthusiasm can devolve into laborious obligations. Then energy flags and ministries and people suffer.

Mixed feelings are a normal part of many human experiences. Ministry with people with serious mental illness is no exception, especially when one chooses deeper levels of involvement. When these mixed feelings are acknowledged and carefully examined, they enhance both the personal growth of the person providing the ministry as well as the one receiving it. For instance, ministering with a person with severe depression can evoke awareness of one's own grief, or ministering with a person with severe panic attacks may bring up one's hidden anxieties. Recognition and deeper understanding of these feelings can bring healing and wholeness to both the one ministering and to the one receiving care. The following are typical feelings that can hamper ministry.

a. *Fear*

Some church members find that they must deal with their fear of persons with mental illness. Such fear often decreases with greater understanding of mental illness. The fear can also be addressed by remembering that persons with mental illness rarely physically harm others. Also, churches can assuage this fear by making sure that experienced staff is present when support groups for people living with mental illness are meeting in church buildings. Often people do not know what to say to a person with mental illness. To treat persons who have a mental illness with kindness and compassion will help, but hearing their life stories will greatly reduce one's anxiety. The more familiar people are with each other the more comfortable they will be.

b. *Discomfort*

Discomfort is a common response to persons with mental illness. It may lead to feelings of repulsion that result in rejection. People with mental illness may act differently, speak differently, dress differently, appear disheveled and have poor personal hygiene. They may also have unusual mannerisms, idiosyncratic behaviors, and unconventional habits. While many people cannot be expected to just overlook these marked differences, seeing people as individuals can lead to an acceptance of some differences and create greater openness to a fuller range of human experience.

c. *Anger*

Anger is another common response. Those who perceive people with mental illness as lazy and "just looking for a hand out" will often respond with frustration or even anger. It is important to separate the person from the illness, by getting frustrated with the illness and not the person. Setting firm and appropriate interpersonal boundaries can also help to reduce frus-

tration and anger, because boundaries give caregivers personal space. Healthy boundaries also train people with mental illness to gauge how their behavior affects others, so that they can develop more positive habits.

d. *Powerlessness*

In an ongoing relation with a person who suffers with serious mental illness, a common impulse is to try to "fix" the problem, to make the suffering go away. However, because it is not possible for human beings to eliminate the problem of serious mental illness, caregivers often feel powerless and helpless in the face of such suffering. This feeling of powerlessness can be very painful. The challenge, then, is to learn to tolerate these feelings in order to be able to stay present and to offer the gift of friendship. When one's powerlessness is accepted, and the pain of it is tolerated, then the caregiver may find a source of power that is beyond the realm of the human and from the realm of the divine. The paradox of powerlessness is such that only in recognizing one's powerlessness does one embrace the Source of all Power.

e. *Joy*

In *Faith & Mental Illness*, Harold Koenig, M.D. writes, "Persons with mental illness challenge faith communities by providing members of those communities with an *opportunity* to live out their faith in a meaningful way. … If the faith community responds by loving, supporting, and including the mentally ill, then it can say with pride that it is carrying out the great commandment."[118] Faith can become dry and dreary, theology can become abstract, and expressions of faith can become mere routine. But in demanding and sometimes difficult service to others, faith is made vividly alive and particularly relevant. Through active service to those with serious mental illness the lives of both the giver and receiver of that service are enriched and both draw closer to God. Ministering to others can fill life with love and joy, even with excitement. When a brother or sister with a serious mental illness is recognized and greeted by name, the joy of that simple act is equally experienced by both. Kindness is contagious. Individuals, families, and faith communities all grow when the stranger becomes friend.

C. *The Church and the Concept of Recovery*

One way to understand the church's role regarding serious mental illness is in terms of "recovery." For centuries serious mental illness was considered to be relentless and lifelong by both the medical community and the general public. It was believed that serious mental illness, particularly schizophrenia, was an illness from which one never recovered. This perception greatly influenced plans of treatment for persons with serious mental illness, the community's regard for these individuals, and the public and private systems designed to treat and care for them. However, with new drug therapies and the organized voices of people with mental illness, their families, and members of the medical community, there emerged a challenge to the notion of permanent incapacity. The focus turned to recovery.[119]

To understand the concept of recovery it is important not to confuse it with the concept of cure. Illnesses can be cured, but one can be in recovery without achieving a cure. Dr. Mark Ragins, a pioneer in the field of integrated services for the mentally ill, writes, "My present conceptualization is that recovery has four components: (1) hope, or a positive vision for the future, (2) empowerment, (3) self-management, and (4) a meaningful role or niche in life."[120] According to Ragins, these four steps are the way we recover from all of life's traumas and they are the same four steps that can be utilized in recovery from mental illness. The recovery concept was also fully embraced by the President's New Freedom Commission on Mental Health. In their 2003 report they proclaimed recovery, which they defined as "… a process in which people are able to live, work, learn and participate fully in their communities …"[121] as the goal of a transformed mental health care system. It is also important to note that the commission emphasized, in particular, the role of hope in the recovery process.[122]

Churches enable recovery when we welcome people with serious mental illness into our fellowship. While churches cannot cure mental illness, they can work with a person with mental illness toward his or her unique recovery goals. One such way of walking with individuals who have mental illness is to offer a service for wholeness and healing that is in accordance with the Scriptures, such as James 5:13–16, and the Directory for Worship, *Book of Order,* W-3.5400. In addition, the Pastoral Liturgies section of the *Book of Common Worship* describes services for wholeness that may be provided within community and to individuals in conjunction with appropriate (medical and psychological) clinical treatment. One advocacy group states, "While serious mental illness impacts individuals in many challenging ways, the concept that all individuals can move towards wellness is paramount."[123]

Grasping the concept of recovery is fundamental to understanding the role of Christian communities in welcoming those with mental illness and working to meet their needs. Well prior to the current emphasis on recovery, the Presbyterian Church (U.S.A.)'s 1988 policy, *Life Abundant: Values, Choices and Health Care*," proclaimed: "Health and wholeness … are not dependent on the absence of impairment or on physical perfection. One can be injured, possessed of a disabling condition, malformed of body, and yet be 'healthy,' quite able to function well if given assistance and opportunity by the community" (*Minutes*, 1988, Part I, p. 536). The Christian community is clearly called to provide that assistance and opportunity to those with mental illness and we are a unique source for that critical component in recovery—hope.

VI. Conclusion

Sing for joy, O heavens, and exult, O earth; break forth, O mountains, into singing!
For the Lord has comforted his people, and will have compassion on his suffering ones. (Isa. 49:13, NRSV).

Though millions still live in the exile of mental illness, God's call to comfort still stands. God goes before us to bring nurture, companionship, healing, and justice in the lives of all people who cry out for comfort. Like all of human life, there are many aspects of serious mental illness that are beyond our control. Together we pray for the courage, patience, and grace to forbear what we cannot change.

There are also arenas where God's people can exercise the extraordinary power of love, compassion, and hospitality. We can do the work of justice where there is discrimination, inhumane treatment, and callous disregard for the humanity of people with serious mental illness. We can trust the power of God to do more than we can ask for or conceive as we wait and watch for signs of God's Reign. We can proclaim the good news that neither pain of body or mind, nor social stigma and discrimination, nor confinement in prison or life on the streets, nor rejection by family and friends, nor any aspect of serious mental illness can separate us from the love of God in Christ Jesus our Lord.

We offer our gratitude to God for the gifts that people with serious mental illness bring to the church and to the world. We are grateful for ministries with people with serious mental illness, for medications and psychotherapies that offer a healing balm, for the skill and compassion of mental health care professionals, for advocates in the areas of the law, health-care benefits, and public policy, and for the love of families for their members with serious mental illness. We are grateful for the wonders of God's love for all people, especially for God's children with serious mental illness. We give thanks for God's redeeming love in Jesus Christ, whose reach is without bounds.

Out of gratitude for all that God has done, we call the Presbyterian Church (U.S.A.), through this policy, "Comfort My People," to go into the diverse places of exile to find God's children with a mental illness or a serious mental illness. We welcome them home to the love and care of full participation, and representation in this branch of the Body of Christ as described in G-4.0403 of the *Book of Orde*r:

> The Presbyterian Church (U.S.A.) shall give full expression to the rich diversity within its membership and shall provide means which will assure a greater inclusiveness leading to wholeness in its emerging life. Persons of all racial ethnic groups, different ages, both sexes, various disabilities, diverse geographical areas, different theological positions consistent with the Reformed tradition, as well as different marital conditions (married, single, widowed, or divorced) shall be guaranteed full participation and access to representation in the decision making of the church. (G-9.0104a)

Appendix A

The Journey of the Task Force on Serious Mental Illness

The Coordinating Committee and staff of the Advisory Committee on Social Witness Policy (ACSWP) reviewed more than one hundred names and resumes submitted by presbyteries, synods, agencies, and individuals in order to select members for the task force wisely. We, the members of the task force, felt, though, that the Holy Spirit selected us and prepared us for this work long before ACSWP appointed us. We approached our labors with varied backgrounds and perspectives, which helped us to work in complimentary ways. We are pastors, clinicians, family members of persons with mental illness, persons who have suffered from mental illness ourselves, and—all save one who is Roman Catholic—Presbyterians. We all advocate for individuals and families affected by serious mental illness, so we were very grateful for this opportunity to serve.

The ACSWP instructed us to draft a serious mental illness report that we would present to the committee, which would take ownership of the report and consider its readiness for submission to the 218th General Assembly (2008). We convened for the first time in Louisville, Kentucky, in May 2005. We learned about our accountability to ACSWP and the process of getting a proposed policy before the General Assembly. Brenda Gales was elected moderator. Tom Davis agreed to record minutes and moderate the list serve to facilitate our online collaboration.

We heard from representatives from the Presbyterian Health, Education, and Welfare Association (PHEWA) and the Board of Pensions of the Presbyterian Church (U.S.A.), and the Presbyterian Serious Mental Illness Network (PSMIN). We organized to complete several early writing assignments: a panel survey, a study guide to educate churches and solicit their feedback; and finally—a rather small project that seemed simple at first, but proved more difficult than we had supposed—a working definition of "serious mental illness." The task force then set its calendar and agenda for the remaining five meetings.

In November 2005, the task force met in Rosemont, Illinois. Lee Butler, associate professor of Theology and Psychology, Chicago Theological Seminary, led us in a Bible study. Joan Blundall, director of the Community Based Initiatives: The Higher Plain, Inc., West Branch, Iowa, informed the task force about issues which rural Americans face who have serious mental illness. The task force heard reports from several Presbyterian congregations engaged in ministry with persons living with serious mental illness: Edgewater Presbyterian Church, Chicago; Fourth Presbyterian Church, Chicago; and, North Presbyterian Church, Kalamazoo, Michigan. Patricia Gleich, associate for National Health Ministries of the PC(USA) described the work of this office. The task force received reports regarding the panel survey

used by the Research Service Office of the PC(USA), and also the study and feedback booklet that was sent to every presbytery and distributed to their member churches.

In February 2006, we convened in Washington, D.C. Some of our sessions were held in the Presbyterian Washington Office (PWO). A paper, "Korean American Perspective on Mental Illness," was presented by task force member, Dr. Kum Ock Kim. The work of the National Alliance on Mental Illness (NAMI) was outlined, especially the issues of legislative and governmental concern. The executive director of the American Association of Pastoral Counselors (AAPC) discussed issues with us, as did the director of Communications and Public Affairs of the American Psychiatric Association (APA). We met with a legislative aid to Senator Barbara Boxer about proposed legislation, particularly regarding medical insurance parity for mental illnesses. We learned that Senator Boxer had introduced legislation regarding mental health care for returning Iraq veterans.

The task force heard from representatives of the Mennonite Central Committee Washington who informed us of resources produced and available through their offices. We viewed a moving video entitled *Shadow Voices*.

Michael Stoops, director of the National Coalition for the Homeless (NCH), and David Harris, a formerly homeless person with serious mental illness, spoke to us about the interrelatedness of homelessness and mental illness. Carolyn Race, former associate for Domestic Poverty and Environmental Issues in the Presbyterian Washington Office, discussed some of the current pertinent legislative issues and anticipated federal budget allocations.

Cynthia Abrams, director of the Alcohol, Other Addictions and Health Care Program of the General Board of Church and Society of the United Methodist Church, addressed the group as a Native American. She spoke about addictions and mental illnesses in various tribes, and how the availability of resources for alleviating these problems varies from tribe to tribe. She spoke of the impact of gaming upon some reservations, and the high rate of suicide among young Native American men.

The task force also heard from L. William Yolton, a retired PC(USA) minister and chair of the local Human Rights Committee in Virginia. He had been a member of PSMIN. The task force then began a lengthy task of writing and rewriting. Assignments were made for our next meeting.

In August 2006, the task force met in San Francisco. A report from Jack Marcum, then the associate for survey research of the General Assembly Council, regarding the results from the *Mental Illness: The Report of the February 2006 Presbyterian Panel Survey* indicated that the returned response was better than usual. The task force heard from representatives of Menlo Park Presbyterian Church, San Francisco, who are members of Hope, Encouragement, Love and Prayer (H.E.L.P.); also from a representative from FaithNet; and a retired National Health Ministries associate of the PC(USA).

We continued to edit drafts of the policy statement. We settled on a unifying theme for the report: "Comfort My People: A Policy Statement on Serious Mental Illness." An outline of the proposed policy was developed. A schedule for materials to be submitted was established and writing assignments made.

In November 2006, the task force gathered in Decatur, Georgia. We met with doctors, nurses, and chaplains in the psychiatric unit of Grady Hospital and discussed spiritual concerns of people living with serious mental illness. We also discussed some cultural dimensions of serious mental illness experienced by racial and ethnic minorities. Finally, we began to consider recommendations to follow from our proposed policy statement, recommendations for various entities with our church and society.

In late February/early March 2007, the task force gathered in San Juan, Puerto Rico. Representatives from the Synod of Puerto Rico and the Evangelical Seminary of Puerto Rico served as hosts for this major review of the proposed policy paper.

Members of the task force shared in a presentation of their work to ACSWP at its summer meeting in 2007 in Louisville, Kentucky. The ACSWP received it with gratitude and commendation, but also recommended suggestions for strengthening the report. In addition, members of the task force shared in presentations of their work to the Synod Consultation on Comfort My People in the fall of 2007 in Louisville, Kentucky, and to the commissioners to the 218th General Assembly (2008) in San Jose, California.

The members of the task force are most grateful to God, the PC(USA), ACSWP, and each other for the opportunity to serve our neighbors in this way. We pray that our work may provide greater comfort, community, and celebration for all God's people.

The members of the Task Force on Serious Mental Illness included:

Robert Butziger, clergy, Presbytery of San Jose; certified pastoral counselor; president, California Counseling Association;

Ethel Charles, elder, Presbytery of New York City; director, Police Athletic League Senior Center;

Mary Helen Davis, M.D., Roman Catholic, Diocese of Louisville; associate clinical professor, University of Louisville School of Medicine; private practice psychiatrist, Integrative Psychiatry;

Thomas C. Davis, Ph.D., retired pastor, New Castle Presbytery; former pastoral psychotherapist and professor of Ethics and Pastoral Care and Counseling, Florida Center for Theological Studies;

B. Gordon Edwards, pastor, Presbytery of Cimarron; ACSWP chair and liaison to the task force;

Timothy Engelmann, Ph.D., layperson, Presbytery of San Francisco; licensed psychologist (Calif.), private practice, First Presbyterian Church, Burlingame, California;

Brenda Gales, elder, Presbytery of Greater Atlanta; retired coordinator, Activity Therapy, Grady Hospital, Atlanta, Georgia, volunteer, health clinic coordinator, Clifton Sanctuary Ministries, Atlanta, Georgia;

Leslie Klingensmith, clergy, Presbytery of National Capital; ACSWP liaison to the task force, resigned from ACSWP and the task force early in the process due to family and professional responsibilities;

Kum Ock Kim, M.D. and pastor, Presbytery of New York City; practicing psychiatrist;

Matt Morse, pastor, Presbytery of Detroit;

José R Rodríguez-Gómez M.D., M.P.H., Ph.D., elder, Presbytery of San Juan, Puerto Rico; professor of Socio-Transcultural Psychology, Carlos Albizu University; professor of Statistics and Research Methods, University of Puerto Rico;

Alyce Woodall, elder, Presbytery of Northern New England, retired university vice president, instructor of the National Alliance on Mental Illness "Family to Family" course.

Consultant: Susan J. Dunlap, Ph.D., clergy, Presbytery of New Hope; assistant adjunct professor of Pastoral Theology, Duke Divinity School.

Staff resource person: Belinda M. Curry, clergy, Presbytery of St. Andrew, associate, Advisory Committee on Social Witness Policy.

Appendix B

Suggested Resources

This list of resources includes materials that the Task Force on Serious Mental Illness gathered through its speakers' presentations, referrals received from individuals and groups, and from the members' research on this subject.

Presbyterian Church (U.S.A.) Resources:

Book of Common Worship. Louisville: Westminister John Knox Press, 1993. This resource provides guidelines for preparation for public worship, which include a service for wholeness. Copies of this publication are available through The Presbyterian Marketplace at http://www.pcusa.org/marketplace/item.list.jsp, or by calling the Presbyterian Distribution Service (PDS), 1-800-524-2612. Specify Item # 219918 when placing your orders.

Living into the Body of Christ: Towards Full Inclusion of People with Disabilities. Louisville: Office of the General Assembly (OGA), 2006. This policy approved by the 217th General Assembly (2006) encourages ongoing advocacy with and on behalf of people with disabilities in local, national, and international contexts. It provides a substantial theological understanding of living with disabilities. A PDF copy of this report can be downloaded from the PC(USA)'s website at http://www.pcusa.org/oga/publications/living-into-the-body-of-christ.pdf. Hard copies are available through The Presbyterian Marketplace at http://www.pcusa.org/marketplace/item.list.jsp or by calling the Presbyterian Distribution Service (PDS), 1-800-524-2612. Specify PDS #OGA-06-091.

The National Health Ministries Office's Serious Mental Illness webpage—
http://www.pcusa.org/health/usa/programs/seriousmentalillness.htm. This website contains information on resources that can be used as worship aids, in group discussions, for the observation of "Presbyterian Serious Mental Illness Awareness Sunday" and all other activities where mental illness is a topic.

The Presbyterian, Health, Education, and Welfare Association (PHEWA)— http://www.pcusa.org/phewa. This website contains information about the Presbyterians for Addiction Action (PAA), the Presbyterian Association of Specialized Pastoral Ministries (PASPM), and the Presbyterian Serious Mental Illness Network (PSMIN).

Honest Talk About Serious Mental Illness, a video for youth and leaders of youth. This resource is designed to facilitate discussions and understanding about the facts and challenges of individual and families living with a mental illness. Promoted as a resource for youth, it is also an excellent resource as an introduction on mental illness for all ages. This resource is available for purchase online with a credit card from The Presbyterian Marketplace at http://www.pcusa.org/marketplace/index.jsp or by calling (800) 524-2612. Please specify PDS order # 095301.

The Congregation: A Community of Care and Healing. This booklet is designed for study sessions, special interest groups, and Sunday school groups. It provides information that will raise awareness on mental illness and how the faith communities can be a support to individuals and families living with a mental illness. This resource is available for purchase online with a credit card from The Presbyterian Marketplace at http://www.pcusa.org/marketplace/index.jsp or by calling (800) 524-2612. Please specify PDS order #25790002.

Report and Resolution on the Church and Serious Mental Illness approved by the 200th General Assembly (1988). The booklet offers recommendations to all entities of the church on how to be in ministries with individuals and families living with a serious mental illness. Included are personal stories from individuals, resources for clergy, congregations, seminaries and other Presbyterian groups. To order a

copy, go to the National Health Ministries Office's webpage http://www.pcusa.org/nationalhealth/resources/mental-illness.htm#communityofcare, or call (888) 728-7228, ext. 8011.

Ecumenical Resources:

Light for All: Worship Resources for Including People with Mental Illness and Disabilities. Mennonite Central Committee Canada, 2001. This collection of worship materials, including sermons, litanies, dramatic readings, calls to worship, and prayers furthers the inclusion of people with mental illness or disabilities in worship life of the congregation. To order: contact the Mental Health and Disabilities Program, 134 Plaza Drive, Winnipeg, R3T 5K9, Phone: 204-261-6381.

Pathways to Promise: Ministry and Mental Illness—http://www.pathways2promise.org/. Pathways to Promise is an interfaith technical assistance and resource center which offers a variety of liturgical and educational materials, program models, and networking information to promote a caring ministry with people living with a mental illness and their families.

Shadow Voices: Finding Hope in Mental Illness Video and DVD, Mennonite Media, 2005. This 94 minute video/DVD has a collection of personal stories from individuals living with a mental illness and help for congregation on understanding mental illness. To order: contact 1251 Virginia Avenue, Harrisonburg, VA 22802, 800-999-3534 or online at http://store.mennomedia.org/. Also refer to http://shadowvoices.com.

"Mental Health as a Key Issue in the Future of Global Health Developments," Tharyan, Prathap, Deepa Braganza, and Prasanna Jebaraj, presented at the Breklum ecumenical consultation on "The Global Health Situation and the Mission of the Church in the 21st Century" held in September 2005 in Breklum Germany. This paper provides an elaboration of a presentation on ways in which churches could play a significant role in partnering with the World Health Organization and the mental health Global Action Programme in bridging the gap between resources and needs in mental health. To download a copy of the paper, go to http://www.oikoumene.org/en/resources/documents/wcc-programmes/justice-diakonia-and-responsibility-for-creation/health-and-healing/09-05-mental-health.html.

Books and Manuals:

Beyond Depression: Toolkit for Medical Providers. The Higher Plain, Inc., 2005. This multi-volume resource was written by individuals who suffer from depression and contains practical and useful information on risk factors, symptoms, diagnosis, treatment, relationships and how to get help.To order: contact The Higher Plain, Inc., 680 Garfield Road, West Branch, IA 52358; Phone: 319-643-5628 or http://www.beyonddepression.info.

Breakey, William. *Mentally Ill and Homeless: Special Programs for Special Needs (Chronic Mental Illness*) New York: Psychology Press, 1998. This practical guide is for practitioners on how to work with the growing population of individual who are living with a mental illness and are homeless. Recommendations and suggestions were derived from six research projects. The guide also provides a discussion on the overall success and/or failure of the projects, preliminary quantitative findings, and the implications for the future of such programs.

Capps, Donald *Men, Religion, and Melancholia: James, Otto, Jung, and Erikson*. New Haven: Yale, 1997. Capps' approach to the psychology of religion integrates the experiences of chronic depression ('melancholy') of leaders in the field into the analysis of their creative work.

Carter, Roselyn, Michael T. Compton, Raymond J. Kotwicki, *Responding To Individuals with Mental Illnesses*, Jones & Bartlett Publishers; 1st edition (December 5, 2006). This practical guide aims to enhance the knowledge and skills for non-mental health professionals who interact with individuals living with a mental illness. Included is information about specific categories of mental illnesses and provide basic skills to enhance interactions by understanding some of the stresses they may be facing.

Dunlap, Susan, *Counseling Depressed Women*. Louisville: Westminster John Knox Press, 1997. This book for pastors and pastoral counselors provides a analysis of women's depression from a feminist theological perspective. It also includes suggestions for effective treatment of women who are depressed.

Gonzalez-Ramos, Gladys, and Manny J. Gonzalez. *Mental Health Care for New Hispanic Immigrants: Innovative Approaches in Contemporary Clinical Practice*. New York: Haworth Social Work, 2005.This resource provides information about the need for culturally effective mental health prevention and treatment models. Designed primarily to be used in secondary and higher educational institutions by professional schools of social work, nursing, psychiatry, and psychology.

Lips, Hilary M. *A New Psychology of Women: Gender, Culture, and Ethnicity*. New York: McGraw-Hill, 2005.An in-depth introduction to the diversity of women in cross-cultural perspective that focuses on various issues including women's mental health, illness, and treatment.

May, Rollo. *My Quest for Beauty*. Dallas: Saybrook 1985. This autobiography of the noted psychologist begins with his experience of a "nervous breakdown" at 21 and emphasizes the role of beauty and art in the re-ordering process.

Stone, Howard. *Depression and Hope: New Insights for Pastoral Counseling*. Minneapolis: Fortress Press, 1998. A resource to use in pastoral counseling placing depression in the larger context of family and society and shows how proper handling of depression by clergy can increase the likelihood not only of a person's strong recovery, but also of a strengthened faith.

Storr, Anthony. *Churchill's Black Dog and Other Phenomena of the Human Mind.* New York: HarperCollins, 1997. The "Black Dog" of depression and other psychic stresses are resisted and utilized in various ways by the figures Storr discusses.

Styron, William. *Darkness Visible: A Memoir of Madness*. New York: Vintage Press, 1992.This book is a personal story by the author about his journey into depression and his recovery from the illness. The author describes his illness as having a tortuous progression and shares in detail his road to recovery.

Torrey, E. Fuller. *Surviving Schizophrenia: A Manual for Families, Patients, and Providers.* New York: HarperCollins, 2006.This book explores the nature, causes, symptoms and treatment in a way that is understandable to the lay reader. It provides lots of useful information for people living with schizophrenia and their family members.

Ulanov, Ann and Barry. *The Healing Imagination: The Meeting of Psyche and Soul*. Zurich: Daimon,1999 (1991). The Ulanovs explore the centrality of imagination in spiritual life, including experiences of being overwhelmed by imagery and of being healed through God's creative presence.

Whitaker, Robert. *Mad in America: Bad Science, Bad Medicine, and the Enduring Mistreatment of the Mentally Ill*. Jackson, TN: Perseus Publishing, Reprint edition (Paperback), 2003.This book is a discussion on the history of the psychiatric treatment of individuals living with a mental illness. It addresses the question of why should living in a country with such rich resources and advanced medical treatments for disorders of every kind be so toxic to those who are living with serious mental illness.

Swinton, John. *Resurrecting the Person: Friendship and the Care of People with Mental Health Problems*. Nashville: Abingdon Press, 2000. The author of this publication presents a discussion on why he feels the church should be a role model in welcoming individual who are living with a mental illness. He shares his experiences in a mental health service facility where patients participated in weekly prayer service and pointed the common ingredients of their prayers. Included in the patients' prayers was the elimination of prejudice toward the mentally ill, understanding of individuals living with a mental illness, and asking forgiveness of other and self-forgiveness. This book is recommended for spiritual directors, chaplains, pastor/minister, and Steven's ministers.

Online Resources:

American Association of Pastoral Counselors (AAPC)—http://www.aapc.org/. The AAPC is a professional agency designed and dedicated to promoting the practice of Pastoral counseling.

American Hospital Association(AHA)—http://www.aha.org/aha/about/index.html. The AHA represents and serves hospitals, health care networks, and their patients and communities. The website for this organization states that this national organization, through it representation and advocacy activities, ensures that the needs and perspectives of its members are heard and addressed in national health policy development, legislative and regulatory debates, and in judicial matters.

American Nurses Association (ANA)—http://www.nursingworld.org/. The ANA represents the nation's registered nurses (RNs). It is the only full-service professional organization representing the RNs.

American Psychiatric Association (APA)—http://www.psych.org/. This medical specialty association is the voice and conscience of modern psychiatry. APA is recognized world-wide. Its member physicians work together to ensure all persons living with a mental disorder receive humane care and effective treatment.

American Psychological Association (APA)—http://www.apa.org/about. APA's mission is to advance psychology as a science and profession and as a means of promoting human welfare, health and education.

Asian American Psychological Association (AAPA)—http://www.aapaonline.org/.The AAPA is the oldest national psychological organization dedicated to advancing the welfare of Asian Americans through the development of Asian American psychology.

Association for Clinical Pastoral Education, Inc. (ACPE)—http://www.acpe.edu/ . The mission of this multifaith and multicultural organization is twofold. The ACPE is devoted to (1) providing education and (2) improving the quality care of ministry and pastoral care offered by spiritual caregivers of all faiths through the clinical educational methods of Clinical Pastoral Education.

Association of Black Psychologists (ABP)—http://www.abpsi.org/. This website explains the work of the Black Psychologist Association whose goals are to have a positive impact upon the mental health of the national Black community by means of planning, programs, services, training, and advocacy.

Center for Mental Health Services' National GAINS Center—http://www.gainscenter.samhsa.gov/html/ . The National GAINS Center is an agency in the Justice System committed to transforming the nations fragmented mental health system and developing a recovery-oriented, consumer-driven system of care. The Center describes it work in its acronym: G - gathering information, A -assessing what works, I - interpreting/integrating the facts, N - networking and S - stimulating change.

Congregational Resources Guide: Mental Health Ministry Resources—http://www.congregationalresources.org/mentalhealth.asp. This website was developed by the National Alliance on Mental Illness (NAMI) Indianapolis Faith Communities Education Project. It is a collection of Mental Health Ministry resources printed, audio-visual, and web-based media for faith communities (congregations and clergy).

Davis, L. Laura. *Adolescent Sexual Health and the Dynamics of Oppression: A Call for Cultural Competency*. Washington, D.C: Advocates for Youth, 2006— http://www.advocatesforyouth.org/publications/iag/oppression.pdf .This article is located on the website of Advocates for Youth: Rights, Respect, and Responsibility. The paper is designed to encourage individuals who work with youth to understand the impact of prejudice and discrimination on vulnerable adolescents.

Disabled American Veterans (DAV)—http://www.dav.org/. This organization represents the interests of disabled veterans and their families. Through its National Legislative Program, DAV is working to ensure that lawmakers are aware of their ongoing concerns.

FRONTLINE: The New Asylums (2005) DVD—http://www.shoppbs.org/product/index.jsp?productId=2000133. Through an in-depth review of the Ohio's prison system, this DVD addresses the alarming number of people with a mental illness incarcerated in America's jails and prisons. There are nearly half a million people living with a mental illness inside these institutions.

Healthy Minds, Healthy Lives Campaign: A program of the American Psychiatric Association— http://www.healthyminds.org/. Healthy Minds, Healthy Lives is designed to provide information that will help college students maintain good mental health.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO)—http://www.qmsonline.com/jcaho.htm. The JCAHO is a not-for-profit organization. It evaluates and accredits about 20,000 U.S. health care organizations and programs; it is the world's leading accrediting and standards-setting body.

Mental Health America (MHA)—http://www.nmha.org/. Mental Health America (formerly known as the National Mental Health Association) provides advocacy, research and statistical data for individuals, agencies and professionals on mental illness.

Mental Health: Culture, Race and Ethnicity—A Supplemental to Mental Health: A Report of the Surgeon General, 2001. To download a copy, go to www.surgeongeneral.gov/library/mentalhealth/cre. This report addresses relevance of culture, race and ethnicity in the incidence and treatment of mental illness.

National Alliance on Mental Illness (NAMI)—http://www.nami.org/. The official website for the nation's largest grassroots mental health organization dedicated to improving the lives of individuals living with serious mental illness and their families.

National Association of Social Workers (NASW)—http://www.socialworkers.org/nasw/default.asp. With 15,000 members, NASW is the world's largest membership organization of professional social workers. This organization works to create and maintain professional standards, to advance sound social policies, and to enhance the professional growth and development of its members.

National Center for American Indian and Alaska Native Mental Health Research (NCAIANMHR)—
http://www2.uchsc.edu/ai/ncaianmhr/journal_home.asp. This is a resource for health care professionals and students in psychology, psychiatry, nursing, sociology and other areas that address mental health and mental illness.

National Coalition for the Homeless (NCH)—www.nationalhomeless.org. This website is design to provide information on the advocacy and service on numerous organizations dedicated to eliminating homelessness.

National Institute of Mental Health (NIMH)—http://www.nimh.nih.gov/ . The NIMH's website states that its "mission is to reduce the burden of mental Illness and behavioral disorders through research on mind, brain, and behavior."

National Latina/o Psychological Association (NLPA)—http://www.nlpa.ws/. The National Latina/o Psychological Association generates and promotes psychological knowledge for the benefit of the Hispanic/Latino population.

National Resource Center on Psychiatric Advance Directives (Refer to Appendix D for an example of an Advance Directive)—http://www.nrc-pad.org/. Psychiatric advance directives are legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

National Youth Violence Prevention Resource Center (NRPC).*Teen Suicide—* http://www.safeyouth.org/scripts/index.asp . This website provides practical advice to teens who may be thinking about suicide and to their families and friends who are concerned about a teen who may be suicidal.

Office of Ethnic Minority Affairs (OEMA) of the American Psychological Association—
http://www.apa.org/pi/oema/homepage.html. This office seeks to recruit and retain psychologists from ethnic minorities and to promote multicultural competence among all psychologists.

Pathways to Promise: Ministry and Mental Illness— http://www.pathways2promise.org/.
Pathways to Promise is an interfaith technical assistance and resource center which offers a variety of liturgical and educational materials, program models, and networking information to promote a caring ministry with people living with a mental illness and their families

Partnership for Workplace Mental Health (PWMH): A program of the American Psychiatric Foundation—
http://www.workplacementalhealth.org/ . This website describes the work of a partnership between The American Psychiatric Association and employers to further the mental health of employees.

Rosalynn Carter Institute for Caregivers—http://rci.gsw.edu/ . This website is the home of the Rosalynn Carter Institute dedicated to building partnerships with local, state and national agencies that are committed to building effective long-term care systems for caregivers, both family and professional.

The State of Depression in America. Chicago, IL: Depression and Bipolar Alliance, February 2006. The State of Depression in America Report examines the economic, social and individual burdens of depression. The report also explores the opportunities to improve the availability and quality of care of individuals living with this illness. To download a copy, go to http://www.dbsalliance.org/pdfs/execsumlo.pdf .

University of Pennsylvania Collaborative on Community Integration, a Rehabilitation Research and Training Center—http://www.upennrrtc.org/. This website provides information on the University of Pennsylvania collaborative on Community Integration promoting community integration for individuals with psychiatric disabilities.

The American Legion—http://www.legion.org/. Congress charted The American Legion in 1919 to serve as a patriotic, mutual-help, war-time organization for veterans. Nine decades later, this organization is still going strong. There are nearly 15,000 American Legions Posts worldwide.

The Wayne E. Oates Institute (Integrating Spirituality, Ethics, and Healing)—http://www.oates.org/. The website for the Wayne E. Oates Institute defines their work as a learning community of professional and lay caregivers--chaplains, counselors, congregational leaders, nurses, physicians, social workers, and others-- seeking to advance care for the whole person. This work is done through education, publication, and research.

The World Health Report 2001— Mental Health: New Understanding, New Hope. Geneva, Switzerland: World Health Organization—http://www.who.int/whr/2001/en/. This is the official site for the World Health Organization (WHO), a specialized agency of the United Nations responsible for directing and coordinating international health projects.

Veterans of Foreign Wars (VFW)—http://www.vfw.org/. The VFW was founded in 1899. This organization was formerly known as the American Veterans of Foreign Service (AVFS). The VFW supports veterans, service members in the U.S. armed forces and their families.

Films:

One Flew Over the Cuckoo's Nest (1975)—Jack Nicholson plays a defiant patient (Randle Patrick McMurphy) in a mental hospital. He has to deal with the cool, cruel Nurse Ratched who rules her domain with an iron hand.

The Fisher King (1991)—Robin Williams plays a mentally ill homeless man (Parry) on a search for the holy grail. The movies tells the story of his relationship with a troubled former DJ, played by Jeff Bridges.

Benny and Joon (1993)—Benny (Aiden Quinn) takes care of his sister, Joon (Mary Stuart Masterson), a talented artist who lives with schizophrenia. Their relationship changes when Joon meets Sam (Johnny Depp).

Mr. Jones (1993)—Mr. Jones (Richard Gere) is a story about a man living with a bipolar disorder. This film explores the manic and depressive side of this mental Illness.

A Beautiful Mind (2001)—This movie tells the story of John Nash (Russell Crowe), a brilliant Princeton mathematician, who develops schizophrenia.

Antwone Fisher (2002)—The story of a young man in the navy (Derek Luke) who confronts his painful past with the help of his psychiatrist Jerome Davenport, played by Denzel Washington.

Sylvia (2003)—This movie tells the story of the relationship between poets Sylvia Plath (Gwyneth Paltrow) and Ted Hughes. Plath, who is best known for her semi-autobiographical novel, *The Bell Jar,* lived with debilitating bouts of depression.

Appendix C
Models of Ministry

Capitol Heights Presbyterian Church, Denver, Colorado—http://chpc.denverpresbytery.org

Celebration of Life Presbyterian Church, Mesa, Arizona—http://www.celebration-of-life.org/

Edgewater Presbyterian Church, Chicago, Illinois (no website-telephone: (773) 561-4748)

First Presbyterian Church, Birmingham, Michigan—http://www.fpcbirmingham.org/default.htm

Fourth Presbyterian Church, Chicago, Illinois—www.fourthchurch.org

Hillsboro Presbyterian Church, Nashville, Tennessee—www.hillsboropresbyterian.org

Menlo Park Presbyterian Church, Menlo Park, California—www.mppcfamily.org

Mount Vernon Presbyterian Church, Alexandria, Virginia—www.mvpconline.org

North Presbyterian Church; Kalamazoo, Michigan—www.northchurchpcusakalamazoo.org

Plymouth Congregational Church, Seattle, Washington—www.plymouth.org

St. Andrew's Presbyterian Church, New Port Beach, California—www.standrewspres.org

San Clemente Presbyterian Church, San Clemente, California—http://zscc.firstmediaworks.com/default.asp

Trinity United Presbyterian Church, Santa Ana, California—www.trinityunitedpres.org

Visit the Presbyterian Health, Education and Welfare Association (PHEWA)'s website to download a free Models of Ministry booklet. Go to: http://www.pcusa.org/phewa/networks/psmin/psmin-models.pdf .

Appendix D

Example of Advance Directives for Mental Health Treatment[124]

Below is an example of material that may be included in an Advance Directive for Mental Health Treatment. Each state has its own format. Go to http://www.nrc-pad.org/, the website for the National Resource Center on Psychiatric Advance Directives, for state-by-state information.

1. Symptom(s) I might experience during a period of crisis: __________

2. Medication instructions:

   A. I agree to administration of the following medication(s): __________

   B. I do not agree to administration of the following medication(s): __________

   C. Other information about medications (allergies, side effects): __________

3. Facility Preferences.

   A. I agree to admission to the following hospital(s): __________

   B. I do not agree to admission to the following hospital(s): __________

   C. Other information about hospitalization: __________

4. Emergency Contacts in case of mental health crisis:

   Name: __________
   Name: __________
   Name: __________
   Psychiatrist: __________
   Case Manager/Therapist: __________

5. Crisis Precipitants. The following may cause me to experience a mental health crisis: ______

6. Protective Factors. The following may help me avoid a mental health crisis: __________

7. Response to Hospital. I usually respond to the hospital as follows: __________

8. Preferences for Staff Interactions. Staff of the hospital or crisis unit can help me by doing the following: __________

9. I give permission for the following people to visit me in the hospital: __________

10. The following are my preferences about ECT: __________

11. Other Instructions.

    A. If I am hospitalized, I want the following to be taken care of at my home: __________

B. I understand that the information in this document may be shared by my mental health treatment provider with any other mental health treatment provider who may serve me when necessary to provide treatment in accordance with this advance instruction. Other instructions about sharing of information are as follows: _____________________

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118. Harold G. Koenig, *Faith & Mental Illness* (West Conshohocken, PA: Templeton Foundation Press, 2005) 142.

119. Joyce Burland, *NAMI Family-to-Family Education Program*, *Teacher's Manual*, January 1990, 10.1.

120. Mark Ragins, M.D., "Sewing a Mental Illness Recovery Banner," cited 21 May 2007, available from http://www.village-isa.org/Village%20Writings/writings_hp.htm.

121. New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America*, *Final Report*, (Rockville, MD: Department of Health and Human Services, 2003), 5.

122. Ibid.

123. NAMI, "Recovery," cited 19 November 2007, available from http//www.nami.org/.

124. Adapted with permission from the form used by the State of North Carolina.

ACREC ADVICE AND COUNSEL ON ITEM 10-05

Advice and Counsel on Item 10-05—From the Advocacy Committee for Racial Ethnic Concerns (ACREC).

Item 10-05. "Comfort My People," a policy statement on serious mental illness.

The Advocacy Committee for Racial Ethnic Concerns (ACREC) advises that Item 10-05 be approved.

COGA AND GAC COMMENT ON ITEM 10-05

Comment on Item 10-05—From the Committee on the Office of the General Assembly (COGA) and the General Assembly Council (GAC).

In order to be good stewards of our resources, the Committee on the Office of the General Assembly and the General Assembly Council urge the 218th General Assembly (2008) not to make exceptions to Standing Rule H.2.a.(12).

The Committee on the Office of the General Assembly and the General Assembly Council remind commissioners and advisory delegates of Standing Rule H.2.a.(12), which reads: "(12) As soon as practicable after the adjournment of the General Assembly, the Stated Clerk shall publish the assembly's proceedings and other documents as the assembly may direct in an appropriate format (i.e. print or electronic) to be determined by the Stated Clerk."

This rule was added to *Manual of the General Assembly* several years ago to help control expenses and maximize distribution of documents.

If the General Assembly decides to make an exception to the rule, it will be necessary for the assembly to suspend the Standing Rules, which requires a 2/3 affirmative vote of the total enrollment of commissioners.

$Item 10-06

[The assembly approved Item 10-06 with amendment. See pp. 58, 59.]

On Supporting Single Payer Universal Healthcare Reform—From the Presbytery of Pittsburgh.

The Presbytery of Pittsburgh overtures the 218th General Assembly (2008) to do the following:

1. [~~Advocate for, educate about, and work toward~~] [Endorse in principle the provision of] single-payer universal health care reform [in which health care services are privately provided and publicly financed.] [~~through national health insurance that is privately provided (improved Medicare for all in principle) and publicly financed.~~]

2. Direct the General Assembly Council[, through appropriate offices including the National Health Ministries, the Washington Office, and the Presbyterian Health, Education, and Welfare Association (PHEWA),] to [~~actively~~] [advocate for, educate about, and otherwise] pursue the goal of obtaining legislation that enacts single-payer, universal national health insurance as the program that best responds to the moral imperative of the gospel; [~~and that the General Assembly Council monitor~~] [monitoring] progress toward this goal [~~without regard to political party~~] and [~~report~~] [reporting] back to the [~~church on an annual basis~~] [next two General Assemblies (2010 and 2012)].