# Mental Health and the Church Forum – Atlanta

**Saturday, May 14, 2016; Intown Community Church, Atlanta, GA**

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<tr>
<th>Time</th>
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<tr>
<td>12:00</td>
<td>Registration and Doors Open.</td>
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<tr>
<td>1:00</td>
<td>Welcome, Prayer and Housekeeping Details.</td>
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<tr>
<td>1:30</td>
<td><em>Session B: Spirituality and Depression: A Historical Perspective - Dr. Sam Thielman.</em> An overview of depression in Church history.</td>
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<td>1:50</td>
<td><em>Session C: Audience Engagement and Perspectives - Ms. Marti Vogt.</em> Collaborative discussion with soliciting feedback related to the state of mental illness resources and ministry within individual congregations. Who is here, degree of diversity, and interest/need for similar forums or training.</td>
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<tr>
<td>2:10</td>
<td><em>Session D: Depression / Bipolar Disorder - Dr. Brian Briscoe.</em> Presentation, Panel Discussion and Q&amp;A.</td>
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<tr>
<td>2:50</td>
<td>Break – Refreshments - Networking</td>
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<tr>
<td>3:15</td>
<td>Breakout Sessions (Rooms Assigned at Forum). <em>Session E: OCD/Scrupulosity/Anxiety Disorder: Dr. John Yarbrough.</em> <em>Session F: Family and Teenage Mental Issues: Dr. Tom Okamoto.</em> Presentation, Panel Discussion and Q&amp;A.</td>
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<tr>
<td>3:55</td>
<td><em>Session G: Psychiatry and Missions - Dr. Barney Davis.</em></td>
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<tr>
<td>4:15</td>
<td>Open Forum Discussion / Identification of Needs and Path Forward</td>
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<tr>
<td>4:50</td>
<td>Closing Remarks / Thank you / Closing Prayer and Meeting Adjourn</td>
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**Session Presenters and Leaders:**

- **Pastor Tony Rose**, LaGrange Baptist Church, KY
- **Dr. Barney Davis**, MD, Psychiatrist, AZ
- **Dr. Sam Thielman**, MD, Psychiatrist, NC
- **Dr. Brian Briscoe**, MD, Psychiatrist, KY
- **Dr. John Yarbrough**, MD, Psychiatrist, CA
- **Dr. Tom Okamoto**, MD, Psychiatrist, CA
- **Ms. Marti Vogt**, Perimeter Church Counseling Network, Atlanta

*(Contact Marshall Williams for Information at psychsectioncmda@gmail.com)*
Mental Health and the Church Forum – Atlanta Resource Package Table of Contents

(https://cmda.org/ministry/page/psychiatry/psychiatry-section-activities-and-resources)

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To Access the Resource Package for the 2016 Forum, and other resources related to Clergy and Psychiatrists and Psychologists Partnering to address Mental Health Issues in the Church, please go to our web-site at: https://cmda.org/ministry/page/psychiatry/psychiatry-section-activities-and-resources

For questions and more information contact psychsectioncmda@gmail.com.
Mental Health and the Church Forum – Atlanta

Welcome

Thank you for attending this Forum. Following are resource materials we have gathered in order to facilitate education about and treatment of Mental Illness.

This Resource Package and information presented during the Forum can be found at: https://cmda.org/ministry/page/psychiatry/psychiatry-section-activities-and-resources

The Center for Disease Control estimates that up to 25 percent percent of adults in the U.S. may develop some form of mental illness in their lifetime. Mental illness can affect persons from all walks of life, regardless of belief or lack of belief in Christ. The church is often the first place people turn to for help and guidance; hence, the church is positioned to bring hope and healing to those seeking help and direction with life’s most difficult issues and challenges. Are you ready?

Sometimes, churches feel unprepared or lacking in resources to effectively deal with mental illness. Hence, many church communities like Saddleback Church in California and others around the country are beginning to host events and conferences designed to educate the church about mental illness—what it is, what it is not, how to recognize it and how to help.

The Psychiatry Section of Christian Medical & Dental Association (CMDA) is a national organization of psychiatrists who share Christian beliefs and values, a commitment to living out their faith through service and medical practice, and a strong understanding of the need to care for the whole person—physical, mental and spiritual. The CMDA Psychiatry Section is holding its annual meeting in Atlanta this year, bringing a number of Christian psychiatrists to the Atlanta area—providing a unique resource to support this event for the local church and Christian community.

As such, the CMDA Psychiatry Section is participating in this forum called Mental Health and the Church Forum – Atlanta. The event brings together local clergy and Christian psychiatrists for a serious, informed discussion of mental illness, its presence in the church and the need to have an open dialogue and understanding within the broader church. This forum is intended to be informational in nature, discussion oriented and focused on equipping the church. We will discuss some of the most common mental health conditions and highlight resources (local and web-based) available to clergy, lay leaders and their congregations. This forum is not intended to provide treatment, but rather to begin resourcing clergy and care ministry leaders who can then touch their congregations.

Ultimately, we hope to spark the beginning of a journey toward better understanding and mutual cooperation between informed mental health professionals and the church.

For more information contact the Psychiatry Section Administrative Assistant at psychsectioncmda@gmail.com.
National Alliance on Mental Illness

Who We Are

NAMI, the National Alliance on Mental Illness, is the nation’s largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness.

What started as a small group of families gathered around a kitchen table in 1979 has blossomed into the nation's leading voice on mental health. Today, we are an association of hundreds of local affiliates, state organizations and volunteers who work in your community to raise awareness and provide support and education that was not previously available to those in need.

NAMI relies on gifts and contributions to support our important work.

What We Do

We educate. Offered in thousands of communities across America through our NAMI State Organizations and NAMI Affiliates, our education programs ensure hundreds of thousands of families, individuals and educators get the support and information they need.

We advocate. NAMI shapes the national public policy landscape for people with mental illness and their families and provides grassroots volunteer leaders with the tools, resources and skills necessary to save mental health in all states.

We listen. Our toll-free NAMI HelpLine allows us to respond personally to hundreds of thousands of requests each year, providing free referral, information and support—a much-needed lifeline for many.

We lead. Public awareness events and activities, including Mental Illness Awareness Week (MIAW), NAMIWalks and other efforts, successfully combat stigma and encourage understanding. NAMI works with reporters on a daily basis to make sure our country understands how important mental health is.

- See more at: https://www.nami.org/About-NAMI#sthash.gw1W1Sko.dpuf
Mental Health Conditions

A mental illness is a condition that impacts a person's thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis. Each person will have different experiences, even people with the same diagnosis.

Recovery, including meaningful roles in social life, school and work, is possible, especially when you start treatment early and play a strong role in your own recovery process.

A mental health condition isn't the result of one event. Research suggests multiple, interlinking causes. Genetics, environment and lifestyle combine to influence whether someone develops a mental health condition. A stressful job or home life makes some people more susceptible, as do traumatic life events like being the victim of a crime. Biochemical processes and circuits as well as basic brain structure may play a role too.

Recovery and Wellness

1 in 5 adults experiences a mental health condition every year. 1 in 20 lives with a serious mental illness such as schizophrenia or bipolar disorder. In addition to the person directly experiencing by a mental illness, family, friends and communities are also affected.

50% of mental health conditions begin by age 14 and 75% of mental health conditions develop by age 24. The normal personality and behavior changes of adolescence may mimic or mask symptoms of a mental health condition. Early engagement and support are crucial to improving outcomes and increasing the promise of recovery.

**ADHD** - Attention deficit hyperactivity disorder (ADHD) is a developmental disorder where there are significant problems with attention, hyperactivity or acting impulsively.

- Treatment; Support; Discuss

**Anxiety Disorders** - Everyone experiences anxiety sometimes, but when it becomes overwhelming and repeatedly impacts a person's life, it may be an anxiety disorder.

- Treatment; Support; Discuss

**Autism** - Autism spectrum disorder (ASD) is a developmental disorder that makes it difficult to socialize and communicate with others.

- Treatment; Support; Discuss
Bipolar Disorder - Bipolar disorder causes dramatic highs and lows in a person’s mood, energy and ability to think clearly.

- Treatment; Support; Discuss

Borderline Personality Disorder - Borderline personality disorder (BPD) is characterized by severe, unstable mood swings, impulsivity and instability, poor self-image and stormy relationships.

- Treatment; Support; Discuss

Depression - Depression is more than just feeling sad or going through a rough patch: it’s a serious mental health condition that requires understanding and treatment.

- Treatment; Support; Discuss

Dissociative Disorders - Dissociative disorders are spectrum of disorders that affect a person's memory and self-perception.

- Treatment; Support; Discuss

Eating Disorders - When you become so preoccupied with food and weight issues that you find it hard to focus on other aspects of your life, it may be a sign of an eating disorder.

- Treatment; Support; Discuss

Obsessive-compulsive Disorder - Obsessive-compulsive disorder causes repetitive, unwanted, intrusive thoughts (obsessions) and irrational, excessive urges to do certain actions (compulsions).

- Treatment; Support; Discuss

Posttraumatic Stress Disorder - PTSD is the result of traumatic events, such as military combat, assault, an accident or a natural disaster.

- Treatment; Support; Discuss

Schizoaffective Disorder - Schizoaffective disorder is characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as depressive or manic episodes.

- Treatment; Support; Discuss
Schizophrenia  - Schizophrenia causes people to lose touch with reality, often in the form of hallucinations, delusions and extremely disordered thinking and behavior.

- Treatment; Support; Discuss

RELATED CONDITIONS

- Anosognosia
- Dual Diagnosis
- Psychosis
- Self-harm
- Sleep Disorders
- Suicide

ABOUT US

- Where We Stand on Public Policy
- NAMI Advocacy
- Our Structure
- Our Finances
- Publications and Reports
- Careers at NAMI
- NAMI Store

GET INVOLVED

- Become a Member
- Create an Account
- Donate
- Take the stigmadtigma Pledge
- What Can I Do?
- Share Your Story
- Take Action on Advocacy Issues
- Attend NAMI National Convention
- NAMIWalks
- Awareness Events
- NAMI on Campus
- NAMI FaithNet
- Law Enforcement
NAMI PROGRAMS

- NAMI Basics
- NAMI Connection
- NAMI Ending the Silence
- NAMI Family Support Group
- NAMI Family-to-Family
- NAMI Homefront
- NAMI In Our Own Voice
- NAMI Peer-to-Peer
- NAMI Parents & Teachers as Allies
- NAMI Provider Education

CONTACT US

- NAMI, 3803 N. Fairfax Drive, Suite 100 Arlington, VA 22203
- Main: 703-524-7600
- Member Services: 888-999-6264
- HelpLine: 800-950-6264
- Press & Media
The Interface between Religion/Spirituality and Mental Health

John Peteet, M.D.
Associate Professor of Psychiatry, Harvard Medical School
Staff psychiatrist, Brigham and Women’s Hospital and Dana-Farber Cancer Institute
Boston, MA

Religion/spirituality (R/S) and psychiatry share a long and complex history. Western medicine originated in an era when illness represented disfavor from the gods, healing involved gaining favor from the divine, and priests had unique roles as healers. During the Middle Ages, the first hospitals developed in monastic communities, and nuns served as nurses. With the Enlightenment came empiricism and reductionistic explanation, which led to major shifts in the Western view of the self and of the human condition. Freud’s militant atheism, and the ascendancy of neurobiology later deepened the split between R/S and psychiatry.

Mutual suspicion persists. A religious figure recently acknowledged that psychiatry and psychology have made useful contributions, but warned that “much of those disciplines are built on a faulty worldview and must be (at least partly) rejected.” (1) In a 2013 telephone survey of a representative sample of 1,001 Americans about mental illness, thirty-five percent of respondents (and 48% of Evangelical, fundamentalist, or born-again Christians) agreed with the statement, “With just Bible study and prayer, ALONE, people with serious mental illness like depression, bipolar disorder, and schizophrenia could overcome mental illness.” (2) For their part, many mental health professionals, who as a group are much less religious than the general public, suspect religion of being judgmental, masochistic, homophobic, misogynistic, and monolithic.

Yet in recent decades interest has grown in the relationship between R/S and health: Twelve Step spirituality is widely valued. Psychoanalysts such as Rizzuto have revised Freud’s understanding of faith. Mindfulness has become mainstream. Palliative Medicine includes spiritual care among its goals. Research has burgeoned into the effects of religion on health (e.g. via positive and negative “religious coping”), and into the neurobiology of spiritual experience. The Joint Commission mandates routine spiritual assessment, reflecting greater appreciation for the role of R/S as a risk or protective factor. Most patients surveyed want R/S included in therapy. Courses, papers, journals and books in this area have proliferated, many sponsored by interest groups within mental health organizations such as the American Psychological Association, the Royal College of Psychiatrists and the World Psychiatric Association. Seven doctoral programs in clinical psychology now exist within Christian universities And while psychiatrists are less religious than physicians in other specialties, Curlin et al. (3) found in a national survey that they are more likely to say it is appropriate to ask patients about spiritual concerns (93% vs 53%) and that they do inquire (87% vs. 49%).

Given these developments, how can religious communities and mental health professionals collaborate to reduce the emotional suffering and the stigma of mental illness, and address patients’ R/S needs? Consider briefly some conceptual and practical aspects of this challenge.
Psychiatry and R/S both aim to enhance human flourishing, understanding this to involve the development of adaptive capacities (for example to be reflective, and regulate emotion), a solid identity, realistic hopes, meaningful activities, authentic relationships, a mature moral life and a balance between autonomy and respect for authority. However, they differ in emphasis and role, with R/S placing greater emphases on growth and transformation toward full functioning than on critical thinking about diagnosis and treatment of disorders, as well as greater emphasis on relationship to the Transcendent and one’s community than on individual mastery as means toward these ends.

From a practical perspective, mental health practitioners differ widely in how they implement their theoretical frameworks, ranging from the individualistic Rational Emotive Therapy of the atheist Albert Ellis to the spiritually sensitive or integrated CBT of David Rosmarin and others, to the theistic integrative psychotherapy of LDS psychologists Scott Richards and Allan Bergin. Religious communities also engage in a wide variety of practices aimed at integrating emotional and spiritual approaches such as healing presence by chaplains, pastoral counseling and psychotherapy, spiritual direction, inner healing prayer and group programs such as Celebrate Recovery or Living Waters.

Yet regular interaction between mental health and spiritual care professionals remains the exception rather than the rule. During one month, 60% of the oncology patients seen in psychiatric consultation at my institution were also known to a chaplain, but no communication took place between the two disciplines. Relatively few seminaries or Clinical Pastoral Education (CPE) curricula devote time to the care of major mental illness, despite the fact that clergy are often the first professionals approached by many individuals with mental health and family problems. Conversely, a minority of psychiatric residency training programs include training in addressing the clinical significance of R/S.

There are good reasons to be concerned about this lack of communication and collaboration. Communities which view spiritual and psychiatric interventions as competing alternatives can discourage much needed medication and therapy. Mentally ill individuals are sometimes not only stigmatized and misunderstood but mistreated, as when a bipolar patient is physically restrained or ejected, or a woman with a trauma history is restrained by male clergy during an exorcism. Conversely, religious individuals discouraged by therapists from participating in faith communities stand to miss out on opportunities to understand their narrative as part of a larger story, enhance their relationship with a forgiving God and supportive others, or finding ways to give back.

Various models of communication and collaboration have recently emerged. Examples include a mental health clinic in a Coptic church on Staten Island; a psychologist accepting regular referrals from a orthodox rabbis in New York, a list serve of Christian therapists used to facilitate referrals in greater Boston; a web-based course on mental health and substance abuse for South Asian pastors; and recent conferences for mental health and spiritual care professionals sponsored by a mental health center in Vermont, by the New Jersey Psychiatric Association, by Saddleback Church in California, and by a consortium of entities in Toronto and Houston.
The diversity of mental health and R/S communities, and the complexity of the interface between them suggest the need to: (1) learn from existing models what has worked well and why; (2) develop practical (case based) approaches to engaging learners in various settings about both the challenges which mental illness presents for R/S communities (e.g. recognizing depression), and those which religious individuals encounter in treatment (e.g. integrating spiritual and psychiatric perspectives on the treatment of their depression); and (3) engage key institutions to promote best practices.
The Mental Health and Faith Community Partnership is a collaboration between psychiatrists and clergy aimed at fostering a dialogue between two fields, reducing stigma, and accounting for medical and spiritual dimensions as people seek care. Convening organizations are the APA, the APA Foundation and the Interfaith Disability Advocacy Coalition, a program of the American Association of People with Disabilities.

The partnership provides an opportunity for psychiatrists and the mental health community to learn from spiritual leaders, to whom people often turn in times of mental distress. At the same time it provides an opportunity to improve understanding of the best science and evidence based treatment for psychiatric illnesses among faith leaders and those in the faith community.

Resources for Faith Leaders

**Mental Health: A Guide for Faith Leaders**  (View )

This guide provides information to help faith leaders work with members of their congregations and their families who are facing mental health challenges.

**Quick Reference Guide**  View

This guide provides a quick reference and overview of the Mental Health: A Guide for Faith Leaders. It is a companion to the Guide.

Additional Resources

- Essays
  - A Conception of the Interface Connecting Faith and Mental Health, Clark S. Aist, Ph.D.
  - The Interface between Religion/Spirituality and Mental Health, John Peteet, M.D.
  - A Call to Healing, Craig Rennebohm, M.Div.
  - Mental Illness and Families of Faith: How Congregations Can Respond, Susan Gregg-Schroeder
- Bibliography of Faith/Mental Health Resources
- Action Alliance for Suicide Prevention Faith Communities Task Force

For more information, contact Amy Porfiri at aporfiri@psych.org. Residents & Medical Students
MENTAL ILLNESS IS COMMON

<table>
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<th>In the United States in the last year:</th>
<th>Suicide is the 10th leading cause of death in the U.S.</th>
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<tbody>
<tr>
<td>- Any mental illness - nearly 1 in 5 people (19%)</td>
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<tr>
<td>- Serious mental illness - 1 in 24 people (4.1%)</td>
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<tr>
<td>- Substance use disorder - 1 in 12 people (8.5%)</td>
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OBSERVABLE SIGNS: Some Signs That May Raise a Concern About Mental Illness

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<th>CATEGORIES OF OBSERVATION</th>
<th>EXAMPLES OF OBSERVATIONS</th>
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<td>Cognition: Understanding of situation, memory, concentration</td>
<td>- Seems confused or disoriented to person, time, place</td>
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<tr>
<td></td>
<td>- Has gaps in memory, answers questions inappropriately</td>
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<tr>
<td>Affect/Mood: Eye contact, outbursts of emotion/indifference</td>
<td>- Appears sad/depressed or overly high-spirited</td>
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<tr>
<td></td>
<td>- Overwhelmed by circumstances, switches emotions abruptly</td>
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<tr>
<td>Speech: Pace, continuity, vocabulary</td>
<td>- Speaks too quickly or too slowly, misses words</td>
</tr>
<tr>
<td>(Is there difficulty with English language?)</td>
<td>- Stutters or has long pauses in speech</td>
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<tr>
<td>Thought Patterns and Logic: Rationality, tempo, grasp of reality</td>
<td>- Expresses racing, disconnected thoughts</td>
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<td></td>
<td>- Expresses bizarre ideas, responds to unusual voices/visions</td>
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<tr>
<td>Appearance: Hygiene, attire, behavioral mannerisms</td>
<td>- Appears disheveled; poor hygiene, inappropriate attire</td>
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<tr>
<td></td>
<td>- Trembles or shakes, is unable to sit or stand still (unexplained)</td>
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COMMUNICATION: When a Mental Health Condition Is Affecting an Individual

- Speak slowly and clearly; express empathy and compassion
- Treat the individual with the respect you would give any other person
- Listen; remember that feelings and thoughts are real even if not based in reality
- Give praise to acknowledge/encourage progress, no matter how small; ignore flaws
- If you don’t know the person, don’t initiate any physical contact or touching

<table>
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<th>EXAMPLES OF COMMON OBSERVATIONS</th>
<th>RECOMMENDATIONS FOR RESPONSES</th>
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<tr>
<td>Loss of hope: appears sad, desperate</td>
<td>- As appropriate, instill hope for a positive end result</td>
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<td></td>
<td>- To the extent possible, establish personal connection</td>
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<tr>
<td>Loss of control: appears angry, irritable</td>
<td>- Listen, defuse, deflect; ask why he/she is upset</td>
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<tr>
<td></td>
<td>- Avoid threats and confrontation</td>
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<tr>
<td>Appears anxious, fearful, panicky</td>
<td>- Stay calm; reassure and calm the individual</td>
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<tr>
<td></td>
<td>- Seek to understand</td>
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<tr>
<td>Has trouble concentrating</td>
<td>- Be brief; repeat if necessary</td>
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<td></td>
<td>- Clarify what you are hearing from the individual</td>
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<tr>
<td>Is overstimulated</td>
<td>- Limit input</td>
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<tr>
<td></td>
<td>- Don’t force discussion</td>
</tr>
<tr>
<td>Appears confused or disoriented; believes delusions (false beliefs, e.g., paranoia)</td>
<td>- Use simple language; empathize; don’t argue</td>
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<tr>
<td></td>
<td>- Ground individual in the here and now</td>
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For more information, see Mental Health: A Guide for Faith Leaders, www.psychiatry.org/faith
IMMEDIATE CONCERN: Approaching a Person With an Urgent Mental Health Concern

- Before interacting, consider safety for yourself, the individual, and others
- Is there a family member or friend who can help?
- Find a good, safe place (for both) to talk
- Express willingness to be there for the person
- Seek immediate assistance if a person poses a danger to self or others; call 911; ask if a person with Crisis Intervention Team (CIT) training is available

SUICIDE: Thoughts of suicide should always be taken seriously. A person who is actively suicidal is a psychiatric emergency. Call 911.

| WARNING SIGNS OF SUICIDE                                      | RISK FACTORS FOR SUICIDE                                                                 |)
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<tr>
<td>- Often talking or writing about death or suicide</td>
<td>- Losses and other events (e.g., death, financial or legal difficulties, relationship</td>
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<tr>
<td>- Comments about being hopeless, helpless, or worthless, no reason for living</td>
<td>breakup, bullying)</td>
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<tr>
<td>- Increase in alcohol and/or drug use</td>
<td>- Previous suicide attempts</td>
</tr>
<tr>
<td>- Withdrawal from friends, family, and community</td>
<td>- History of trauma or abuse</td>
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<td>- Reckless behavior or engaging in risky activities</td>
<td>- Having firearms in the home</td>
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<td>- Dramatic mood changes</td>
<td>- Chronic physical illness, chronic pain</td>
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<tr>
<td>- Losses and other events (e.g., death, financial or legal difficulties, relationship breakup, bullying)</td>
<td>- Exposure to the suicidal behavior of others</td>
</tr>
<tr>
<td>- Previous suicide attempts</td>
<td>- History of suicide in family</td>
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WHEN TO MAKE A REFERRAL

Assessing the person
- Level of distress – How much distress, discomfort, or anguish is he/she feeling? How well is he/she able to tolerate, manage or cope?
- Level of functioning – Is he/she capable of caring for self? Able to problem solve and make decisions?
- Possibility for danger – danger to self or others, including thoughts of suicide or hurting others

Tips on making a mental health referral
- Identify a mental health professional, have a list
- Communicate clearly about the need for referral
- Make the referral a collaborative process between you and the person and/or family
- Reassure person/family you will journey with them
- Be clear about the difference between spiritual support and professional clinical care
- Follow-up; remain connected; support reintegration
- Offer community resources, support groups

DEALING WITH RESISTANCE TO HELP

Resistance to seeking help may come from stigma, not acknowledging a problem, past experience, hopelessness, cultural issues, or religious concepts
- Learn about mental health and treatments to help dispel misunderstandings
- Continue to journey with the person/family; seek to understand barriers
- Use stories of those who have come through similar situations; help the person realize he/she is not alone and people can recover
- Reassure that there are ways to feel better, to be connected, and to be functioning well
- If a person of faith, ask how faith can give him or her strength to take steps toward healing

If you believe danger to self or others is imminent, call 911

References
Substance Abuse and Mental Health Services Administration (SAMHSA)
National Suicide Prevention Lifeline, Suicide Prevention
American Association of Suicidology, Warning Signs and Risk Factors
Judges Criminal Justice/Mental Health Leadership Initiative, Judges Guide to Mental Illness
Mission Peak Unitarian Universalist Congregation, Mental Health Information for Ministers
Interfaith Network on Mental Illness, Caring Clergy Project

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1000 Wilson Blvd., Suite 1825,
Arlington, VA 22209-3901
psychiatry.org/faith

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Bibliography

Publications


Please Note that this Mental Health and Faith Community Partnership Steering Committee Meeting Bibliography is a product of the American Psychiatric Association, and can be found at: https://www.psychiatry.org/psychiatrists/cultural-competency/faith-community-partnership


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Books


Please Note that this Mental Health and Faith Community Partnership Steering Committee Meeting Bibliography is a product of the American Psychiatric Association, and can be found at: [https://www.psychiatry.org/psychiatrists/cultural-competency/faith-community-partnership](https://www.psychiatry.org/psychiatrists/cultural-competency/faith-community-partnership)


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**Book Chapters**


**Websites**

American Psychiatric Association: Caucus on Spirituality, Religion and Psychiatry:
http://spiritualityreligionpsychiatrycaucus.com/

Please Note that this Mental Health and Faith Community Partnership Steering Committee Meeting Bibliography is a product of the American Psychiatric Association, and can be found at: https://www.psychiatry.org/psychiatrists/cultural-competency/faith-community-partnership
Bay Area Jewish Healing Center  
http://www.jewishhealingcenter.org/mentalhealth.html

Caring Clergy Project  
http://www.caringclergyproject.org/makingreferrals.html  
http://www.caringclergyproject.org/suicidepreventioninterventionresponse.html

Grounded in Faith: Resources on Mental Health and Gun Violence  
http://www.aapd.com/assets/grounded-in-faith-resources.pdf

Interfaith Network on Mental Illness  
www.inmi.us

Leadership Council for Healthy Communities  
www.lchcnetwork.org

Mental Health Ministries  
www.MentalHealthMinistries.net

Mental Illness Ministries  
www.miministry.org

Muslim Mental Health  
http://www.muslimmentalhealth.com

Pathways to Promise  
http://www.pathways2promise.org/

Reimaging Life Together  
http://www.reimagininglifetogether.org/event/walking-together-conference/

Royal College of Psychiatrists (UK) Spirituality and Psychiatry Special Interest Group:  
http://www.rcpsych.ac.uk/workinpsychiatry/specialinterestgroups/spirituality.aspx

Sanford, M. Rethinking mental health care: the role of the church in recovery.  
http://ibpf.org/article/rethinking-mental-health-care-role-church-recovery

UJA Federation of New York  
http://www.ujafedny.org/shabbat-of-wholeness-tool-kit/

Union for Reform Judaism  
http://urj.org/life/community/health/mental/

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Bibliography is a product of the American Psychiatric Association, and can be found at:  
https://www.psychiatry.org/psychiatrists/cultural-competency/faith-community-partnership
United Church of Christ Mental Health Network
http://www.mhn-ucc.blogspot.com/

World Psychiatric Association: Section on Religion, Spirituality and Psychiatry:
http://www.religionandpsychiatry.com/

Webinars

A Demographic Overview of Latino Adolescents and Young Adults, and their Health Coverage Needs
http://nned.net/docs-general/Webinar1_YoungAdultLatinos10-16-2013.pdf

Barriers & Challenges in Meeting the Health Coverage Needs of Latino Youth and Young Adults
http://nned.net/docs-general/Webinar2-3_BarriersChallenges.pdf

How churches can promote recovery
The International Bipolar Foundation (IBPF) webinar. This webinar presented a clinical, Biblical and personal perspective of psychiatric disorders. The role of the church was discussed as well as practical ways that members can minister to people who have a psychiatric disorder and promote their recovery.

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**Additional Resources**

(General Resources which may or may not be Faith Based. Provided for reference only and for use at the discretion of the user.)

**Hot Lines:**
24-hour National Suicide Prevention Lifeline. Call 1-800-273-TALK (1-800-273-8255); TTY: 1-800-799-4TTY (4889) to talk to a trained counselor

**Web Sites:**
- National Institute of Mental Health - NIMH.gov
- National Alliance on Mental Illness - NAMI.org
- Depression and Bipolar Support Alliance - DBSalliance.org
- American Academy of Child and Adolescent Psychiatry - Aacap.org
- Heart Life Professional Soul Care - Heartlifesoulcare.org
- Suicide Prevention Resource Center – SPRC.org
- Mental Health America – mentalhealthamerica.net
- Georgia Suicide Prevention Information Network - gspin.org
- 211 united Way. Local and national
- Behavioral Health Link - mygcal.com
- American Foundation for Suicide Prevention - AFSP.org
- Suicide Prevention Action Network (SPAN) USA - spanisa.org
- Will To Live Foundation - will-to-live.org/

**Trainings:**
- Mental Health First Aid Training - Mentalhealthfirstaid.org
- QPR. Question Persuade Refer - QPRinstitute.com
- SAFE Talk Training - AFSP.org
- Applied Suicide Intervention Skills Training (ASIST) - livingworks.net/programs/asist/
- NAMI Family to Family - Nami.org
- Lou Ruspi Jr. Foundation - louruspijrfoundation.com/
- Words Can Work - wordscanwork.com
- Armed Forces Mission - nomoresuicide.com
- Sources of Strength - Peer resilience programs
- SOS. Signs of Suicide Gatekeeper Training - mentalhealthscreening.org/gatekeeper
- Kids on The Block - kotb.com

**Books:**
Studies show that when people are struggling with mental illness, the first place they call is the church. Let’s be ready.

"Your greatest ministry will flow out of your greatest pain." — Pastor Rick Warren

The commitment of Saddleback Church to people living with mental illness greatly increased on April 5, 2013 when Pastor Rick and Kay’s youngest son, Matthew, took his life after a lifelong struggle with mental illness. In the midst of the devastating loss of Matthew, Pastor Rick and Kay along with the Saddleback community, have united together to journey alongside people living with mental illness and their families in a holistic way.

The Hope for Mental Health Ministry extends the radical friendship of Jesus by providing transforming love, support, and hope through the local church. The heart of this ministry comes from three passages of Scripture: "I have called you friends, for everything that I learned from my Father I have made known to you" (John 15:15), "Serve one another in love" (Galatians 5:13b), and "May the God of hope fill you with all joy and peace as you trust in Him, so that you may overflow with hope by the power of the Holy Spirit" (Romans 15:13).

Five life-transforming Scriptural truths that shape our approach to the Mental Health Ministry are illustrated in The Hope Circle: you are loved, you have a purpose, you belong, you have a choice, and you are needed.

Materials Developed by and Found at Saddleback Church’s, Hope for Mental Health Ministry. See http://hope4mentalhealth.com/about/our-purpose for more information and ordering.
RESOURCES AVAILABLE FROM SADDLEBACK CHURCH,
LAKE FOREST, CALIFORNIA

Learn how you can start a mental health ministry in your church.

Hope for Mental Health Ministry
Starter Kit

Journey Toward Hope –
A Guided Experience

Hope For Mental Health
Pastor’s DVD

Mental Health Resource Guide for
Individuals and Families

Materials Developed by and Found at Saddleback Church’s, Hope for Mental Health Ministry. See http://hope4mentalhealth.com/about/our-purpose for more information and ordering.
THE DOCTOR.....A MORTAL MAN

“It becomes every man who purposes to give himself to the care of others seriously to consider the four following things:

First that he must one day give an account to the Supreme Judge of all the lives entrusted to his care.

Secondly, that all his skill, knowledge, and energy, as they have been given him by God, so they should be exercised for His glory, and the good of mankind, and not for mere gain or ambition.

Thirdly, and not more beautifully than truly, let him reflect that he has undertaken the care of no mean creature, for, in order that we may estimate the value, the greatness of the human race, the only begotten son of God became himself a man, and thus enabled it with His divine dignity, and far more than this, died to redeem it.

And fourthly, that the doctor being himself a mortal man, should be diligent and tender in relieving his suffering patients, inasmuch as he himself must one day be a like sufferer.”

Thomas Sydenham (1624-1689)

YOU ARE INVITED TO JOIN US

“The Christian Medical & Dental Associations is pleased to offer networks for specialty professionals who share common values and commitments. I encourage you to join your psychiatric colleagues for fellowship, encouragement, and challenge as you integrate your personal faith with your professional practice.”

David Stevens, M.D.
Executive Director
Christian Medical & Dental Associations

Write for an application:

The Psychiatry Section
Christian Medical & Dental Associations
PO Box 7500
Bristol, TN 37621
888-230-2637
423-844-1005 Fax
psychsectioncmda@gmail.com
www.cmda.org/psychiatry

The Christian Medical & Dental Associations’ Psychiatry Section investigates and incorporates the relationship between our faith and our professional practice.
The PSYCHIATRY SECTION of the Christian Medical & Dental Associations

WHAT IS THE PSYCHIATRY SECTION?
A specialty section of the Christian Medical & Dental Associations (CMDA). One does not have to be a member of CMDA to join the Psychiatry Section, although membership is encouraged.

WHO CAN BE A MEMBER?
Active membership is open to all interested psychiatrists and residents in psychiatry training who are members of a state, local, or national medical organization. Members must be in agreement with the Section's purposes, beliefs, and program, and be active in attendance and payment of dues. Associate membership is available to physicians in other specialties and PhD’s who have an interest in psychiatry.

WHAT DOES THE PSYCHIATRY SECTION DO?
Three newsletters are published each year to keep members abreast of Section meetings and information of interest to Christian psychiatrists. A directory is published every other year to assist members with networking and referrals. Our website at provides useful information about the Section for those interested in residency programs.

WHERE DOES THE SECTION MEET?
Since 1961 the Psychiatry Section has met concurrent to the annual American Psychiatric Association meeting. Fellowship at other psychiatric conferences such as AACAP and national CMDA conference is encouraged.

ANNUAL MEETING ACTIVITIES
The Psychiatry Section gathers at the APA annually for the purposes of providing fellowship and study of issues through:

- breakfast talks on topics which engage mind and soul
- social gatherings and worship to facilitate mutual sharing, support, and encouragement.
- a half-day Integration Seminar designed to help members integrate their Christian faith with the practice of psychiatry.
- a dinner meeting with an outstanding speaker to address issues of interest or concern.

In addition, a booth in the APA exhibit area manned by volunteers and staff provides a means of outreach to all participants of the APA and a Christian presence in the marketplace of ideas.

HOW MUCH ARE DUES?
Dues are $100 per year for practicing physicians, $50 per year for retired physicians and free for residents and missionaries.

OUR STATEMENT OF PURPOSE
To stimulate Christians in the practice of psychiatry to investigate and discuss the relation between their faith and professional practice and to incorporate such examined beliefs into their daily practice.

To promote in the Christian community an understanding and use of valid psychological principles, consistent with Christian beliefs. To contribute to the national and local ministry of CMDA through participation, prayer and sharing of our activities.

To join in the ministry of international Christian missions.

To present a positive witness of God our Father, and Jesus Christ our Savior, to colleagues, patients and society.

OUR STATEMENT OF FAITH
(While each of us hold fast to additional beliefs important to our relationship with God, the following statement outlines the tenets that provide a foundation for our fellowship and participation in the Christian Medical Association.)

We believe: In the divine inspiration and final authority of the Bible as the Word of God; In the eternal God revealed in Holy Scripture as Father, Son and Holy Spirit; In the unique Deity of Jesus Christ, God’s only Son, whose death and resurrection provide by grace through faith the only means of my salvation; In the transforming presence and power of the Holy Spirit.