The Role of the Faith-Based Community as Bridge Builders to the Treatment Community for People with Serious Mental Illness (SMI)

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What is SAMHSA?

• A branch of the U.S. Department of Health and Human Services.

• Established by Congress in 1992 when the former Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) was reorganized.

• Leads public health efforts to advance the behavioral health of the nation.
SAMHSA initiates programs and campaigns offering information, training and technical assistance to improve the quality of nationwide behavioral health services.

Collects data on priority topics, such as serious mental illness (SMI), serious emotional disturbance (SED) and opioids, among others.

Issues grants supporting programs for substance use disorders and mental illness.
The Big Picture: 2018 – Illicit Drug Use

Figure 10. Past Year Illicit Drug Use among People Aged 12 or Older: 2018

- No Past Year Illicit Drug Use: 220.6 Million People (80.6%)
- Past Year Illicit Drug Use: 53.2 Million People (19.4%)

- Marijuana: 43.5M
- RX Pain Reliever Misuse: 9.9M
- RX Tranquilizer or Sedative Misuse: 6.4M
- Hallucinogens: 5.6M
- Cocaine: 5.5M
- RX Stimulant Misuse: 5.1M
- Inhalants: 2.0M
- Methamphetamine: 1.9M
- Heroin: 808,000

Number of Past Year Users

Rx = prescription.

Note: The estimated numbers of past year users of different illicit drugs are not mutually exclusive because people could have used more than one type of illicit drug in the past year.

Figure 6. Current, Binge, and Heavy Alcohol Use among People Aged 12 or Older: 2018

16.6 Million Heavy Alcohol Users
(24.7% of Binge Alcohol Users and 11.8% of Alcohol Users)

67.1 Million Binge Alcohol Users
(48.0% of Alcohol Users)

139.8 Million Alcohol Users

(Center for Behavioral Health Statistics and Quality, 2019, p. 12)
Figure 55. Past Year Substance Use Disorder (SUD) and Serious Mental Illness (SMI) among Adults Aged 18 or Older: 2018

27.6 Million Adults Had Either SUD or SMI

19.3 Million Adults Had SUD

16.2 Million Adults Had SUD and SMI

3.2 Million Adults Had SMI but Not SUD

8.2 Million Adults Had SMI but Not SUD

11.4 Million Adults Had SMI

(Center for Behavioral Health Statistics and Quality, 2019, p. 46)
To develop research approaches and collect information/data regarding specific topics related to SMI & SED, SAMHSA held a series of Expert Panel Meetings (EPM) in FY18.

SAMHSA held an Expert Panel Meeting with the **HHS Partnership Center: The Center for Faith and Opportunity Initiatives**.

Shannon Royce, Director, Center for Faith-Based and Community Partnerships.

Leads the Department’s efforts to build and support partnerships with faith-based and community organizations.

Assists HHS in achieving one of its goals – addressing serious mental illness.

Seeks to remove barriers to full and active engagement by the faith-based community and to champion religious liberty in all HHS programs & initiatives.
• 9/12/2018 – Representatives of the Faith-Based Community from across the country gathered in Rockville, MD.

• Topic of the EPM: “The Role of the Faith-Based Community as Bridge Builders to the Treatment Community for People with SMI.”
Meeting Objectives:

• Identify effective models to educate and engage faith leaders in the care of people with SMI.

• Identify challenges to building bridges between the treatment community and the faith-based community.

• Begin to develop an initial priority list of resources to assist faith leaders in understanding crisis situations and appropriate referrals to professional treatment.

• Develop a plan to disseminate resources.
“Twenty-five percent of people who find themselves in a mental health crisis call the church before they seek out a mental health professional or their primary care physician. They go to the church first, because it is a trusted source of help in a community. That said, 71% of the clergy surveyed feel inadequately trained to recognize mental illness.” (Warren 2018)
People often turn to the faith community first when experiencing life’s challenges (APAF, 2016).

Nearly one-quarter of individuals, who are seeking help with a mental health issue, will go to their clergy member first (Wang, 2003).

Clergy have been contacted about mental health concerns more often than psychiatrists (16.7 percent) or general medical doctors (16.7 percent) (Wang, 2003).

Nearly one in four U.S. congregations (23%) provided some type of programming to support people with mental illness. Approximately 31% of all attendees belonged to a congregation that provided mental health programming (Wong, 2018).
Suicide & the Faith-Based Community:

- 1/4 – Number of people considering suicide who will seek out clergy or faith-based leadership (Mason, 2011).

- Participating in religious activities may be a protective factor for suicide (Kleiman, 2018).

- A systemic review of faith-based research shows religious affiliation did not affect suicidal ideation, but it did protect against suicide attempts and death by suicide (Lawrence, 2016).
LifeWay Study of Acute Mental Illness & Protestant Faith:

- Ed Stetzer, Ph.D., Executive Director, Billy Graham Center, Expert Panelist.

- 54% of all Americans & 64% of self-identified born-again, evangelical or fundamentalist Christians think *Christian churches should do more to prevent suicide in America today.*

- “If I had a mental health issue, I believe most churches would welcome me.”: 55% who never attend worship services; 21% who attend worship services once a week or more.

  (Slides 14-15, Stetzer, 2018)
• 56% of Protestant Pastors strongly agree local churches have a responsibility to provide resources and support to individuals with mental illness and their families.

• 66% of pastors speak to the church in sermons or large group messages about mental illness.

• 65% of families of people with mental illness want the church to talk openly about mental illness.

• 59% of people with a mental illness want the church to talk openly about mental illness.
Family & Caregivers Experience:

• One speaker had a son diagnosed as bi-polar who committed suicide weeks after being taken off medication by a new psychiatrist (Warren, 2018).

• One speaker has a mother with schizophrenia. The speaker’s father was a rural pastor. After her father left the pastorate and moved to a city, they suffered poverty, stress, and several hospitalizations for the mother (Simpson, 2018).

• One speaker adopted four children through the child protection system. All four are diagnosed with mental illness, such as bipolar disorder and schizophrenia. Two of the children were born drug addicted, and one became drug addicted later in life (Rosati, 2018).
Family & Caregiver Perspectives Takeaways:

• Families cannot share their struggles regarding being caretakers for those with mental illness due to stigma.

• Caregivers felt their faith community was not supportive and blamed them for not praying enough and demonstrating enough faith.

• Caregivers felt it was difficult to request assistance from their faith community because the community wanted to hear “everything is all better.”

• The caregivers often felt rejected by the faith community who responded with silence.
Gateway to Hope Program (Houston, TX); Matthew S. Stanford, Ph.D., CEO Hope & Healing Center & Institute:

• A community-based approach to mental health care.

• Focused on overcoming barriers to mental health care, such as accessibility, affordability, and acceptability.

• Based on the belief the system is broken and moves people to acute psychiatric hospitalization while bypassing community resources.

(Slides 18-19, Stanford, 2018)
• Trains community churches free of charge to recognize mental health problems, how to make referrals with a service database, how to work with families in distress, and how to restore individuals in the community with support.

• Program is base on three levels of support: Empower, Transform, and Renew. Renew equips a peer mental health coach who goes back to the faith community and becomes the connection to the mental health system.

• Use of a “Thrive” workbook – teaches skills to mental health coaches and is integrated with their faith.
Key Ministry – Stephen Grcevich, M.D., President, Key Ministry:

- Families they reach are rarely associated with the church.

- Data Analysis from the National Children’s Health Survey found that children with mental health conditions are less likely to experience church.

- Attributes of common mental conditions cause difficulty functioning in common ministry environments.

- Church culture places expectations on how people should act during gatherings.

(Slides 20-22, Grcevich, 2018)
Key Ministry Continued:

• **Seven Barriers** to including families with SMI in church: stigma, anxiety, capacity for self-discipline; sensory processing differences; necessary social communication skills; social isolation, and past experiences of church.

• **TEACHER Model**: assemble team, create welcoming environments, ministry activities most essential to spiritual growth, communication, help with needs, educate; empower people to assume responsibility for ministry.
A Parent’s Lament:

“People in the church believe they can tell when a disability ends and bad parenting begins.”
A Consultation Model - Engaging Mental Health Professionals & Faith-Based Community Partners; David H. Rosmarin, Ph.D., Director, McLean Hospital (Belmont, MA/Harvard Affiliated), Spirituality & Mental Health Program:

- Many patients wish to address spirituality in the context of therapy. 58.2% of acute psychiatric patients report “fair” or greater interest in spiritually-integrated mental health treatment.

- Psychiatrists are the least religious/most uncomfortable discussing spirituality.

(Slides 23-25, Rosmarin, 2018)
Of Psychiatrists:

• 21% rarely/never inquire about spirituality/religion when a patient suffers from anxiety/depression.

• 13% do not ever inquire about patients’ religious/spiritual issues.

• 13% say “general discomfort” is a barrier to discuss religion/spirituality with patients.

• 9% sometimes often or always try to change the subject in a tactful way when patients bring up religion/spirituality.
Removing bias is essential to coordinating care across the continuum of care.

McLean is training mental health professionals to:

1) Provide spiritually-sensitive evidence-based care;

2) Consult with and glean recommendations from patients and clergy, and

3) Engage in PRN (as needed) follow up with patients and clergy.
A Leap of Faith: A Foundation Strategy, Vicky Coffee, Program Manager, Hogg Foundation for Mental Health:

- The foundation funded faith-based mental health services because of the historical role of the Black church; clergy are seen as leaders.

- A 3-yr. grant program funded $1 million from 2014-2017 for 10 Texas churches.

- The grant educated African-American faith communities about health, wellness and recovery and connected congregants with local resources.

- Educational strategies were faith-based mental health conferences and Mental Health First Aid for congregants and faith leaders.

(Slide 26, Coffey, 2018)
Reimagining Health Collaborative (RHC), Warren Kinghorn, M.D., Th.D., Co-Director, Theology, Medicine, and Culture Initiative, Duke Divinity School:

- A project of the Theology, Medicine, and Culture Initiative at Duke Divinity School – connecting theological education/Christian faith with the world of health care.

- Christian congregations are equipped for innovative practices of mental health in their communities.

- RCH works with clergy/lay persons in 27 diverse Christian congregations/organizations in NC, VA, MD, TN, IN, & TX.

(Slides 27-28, Kinghorn, 2018)
RHC has enabled participants to minister to 1,420 congregants and 2,112 community members through various programs.

Examples:

1) The Columbus FAITH coalition in NC works to develop solutions to transportation problems to mental health appointments, decrease financial barriers to care and reduce stigma.

2) The Wilson Temple UMC, Raleigh, NC, assembled a mental health team to better support congregants with SMI.
The power of peer-to-peer support is not to be overlooked. Mental health navigators are crucial to assisting those with SMI (Hoefs, 2018).

People can simultaneously have a mental health and a spiritual crisis (Abassi, 2018).

When the faith community cannot talk about mental health and suicide prevention, it feels like God is removed and silent (Arnold, 2018).

Faith groups can connect and form community through small groups offering support; invite mental health practitioners to educate and post mental health information on bulletin boards/ Facebook pages (Clinton, 2018).
• We should be “stone catchers” (Stevenson, 2016) to bridge those in need with those who don’t understand what they need.

• God is not helpless among the ruins (Liddell, 1985).

• For some people the faith community is the last safe place to seek help.

• “Casserole Theme”: Mentally ill people need someone to come and pray for them like people who are physically ill. Pastors need to bring something to the table for those who are mentally ill.
The faith community can be a place of recovery and transformation. Faith is a local experience. We replicate national models as they fit into our community.

Include people who are not professionals in the system. Ex: parents to parents; siblings to siblings, etc.

Use research & data to your advantage. Data changes the provider’s behavior. Data must be translated in a way accessible to others.
• People bring to us the things that matter to them. Our job is to meet them at that place.

• Assist faith-based organizations desiring federal funding. What infrastructure do they need? Help them build that infrastructure.

• Educate seminaries, theological organizations, local groups, etc. regarding SMI.

• Create “mental health literate” organizations.
Themes Continued:

• Dispel myths about mental illness.

• Address the stigma of mental illness.

• Create realistic expectations in faith-based organizations and community organizations.

• Recognize there will be challenges in distinguishing mental illness from a crisis of faith.
1) What do faith leaders need to know to connect to the mental health system and provide more support for those struggling with SMI?

- Disseminate resources and faith-based models. Educate clergy and faith-based leaders on these topics.

- What does mental health literacy look like?

- What does a mental health curriculum or training program look like?

- Develop a practical response for your area – do you start small or go city-wide?
2) How can clinical providers develop more cultural competency about the deeply held religious convictions of their potential/active clients?

- Encourage shifts in perspective/culture to include spiritual needs of clients.

- Use the significant research available to encourage training in spirituality as a cultural competence.

- Develop accreditation & training programs for addressing standards for spiritual competency.

- Educate providers regarding patient rights and their right to discuss/include spirituality in their treatment.
3) What are the key elements of models that connect to the mental health system and integrate faith-based leaders into systems of care? How do we expand these efforts into more communities?

- Standardization of certification for faith leaders regarding understanding mental illness.

- Focus on clergy leaders other than the pastor.
Principles Continued:

- Train clergy in trauma care (Mental Health First Aid)

- Train clergy to see themselves as “patient advocates” for those in their faith-based communities with SMI.

- Address the funding issue for the faith-based community. How will training be financed?

- Teach the faith community that the mental health system offers holistic care for the whole person and care for the whole family.

- Train clergy how to make appropriate referrals to community mental health professionals.
Principles Continued:

• Explain that a mental health crisis is a spiritual crisis and vice versa. Integrate faith into systems of care that don’t allow faith.

• Discuss model sustainability. Mental health issues can be chronic.

• How do faith-based leaders know where to refer in their communities? How do they know if this is a faith-affirming provider? Providers must not see faith as a “pathology.”

• Train residents and providers on the importance of integrating faith into care.
Principles Continued:

• Use available data and research to show the importance of integrating faith into care to mental health providers who are not “faith friendly.” Journals in which present research is published are not mainstream in academia. Show them the research.

• Develop peer to peer support in the faith-based community.

• Show faith-based leaders how to be advocates by attending appointments with people with SMI, etc. (being physically present).
4) **What is the role of faith communities in respect to caregivers and those impacted by SMI?**

- Use community groups to offer respite and give support, such as the Jaycees, etc. Many of these groups amass community service hours for these types of activities (cooking, visiting, food delivery, etc.)
Principles Continued:

• Offer peer to peer support of caregivers who have family members with SMI. Church members can provide transportation, offer faith-based support, provide meals, etc. (Everybody gets a casserole.)

• Create a formal peer-to-peer support network specifically for caregivers in the faith community caring for family members with SMI.
Principles Continued:

• Provide mental health training to members participating in peer to peer support to dispel myths about mental illness and stigma surrounding mental illness.

• Connect caregivers to caregivers – create networks.

• Address SMI in sermons to educate and break stigma in the faith-based community. Make it easier for people to reach out to others.
Principles Continued:

• Engage civic groups to develop guides of mental health services in the community. Larger cities will likely have these already available.

• Task caregivers to map resources by community or state for other caregivers.

• Create small support groups for caregivers.
Principles Continued:

• Complete a community needs assessment to determine what mental health services are needed by your community. Determine if a university or agency (state/local) has already completed a needs assessment. Review what your community needs, and try to meet a need through your faith-based organization.

• Begin to see caregivers as a constant in the mental health system. SMI can be chronic.
We can view support of those with SMI as a four-legged table:

1) Family Caregivers
2) Faith Community
3) Government/Non-Profits
4) Medical Community

The person with SMI is cradled on top.

(Slide 45, Royce, 2018)
Faith-Based Resources:

• “Faith Community Mental Health Resource Index”

• Being developed by the HHS Center for Faith and Opportunity Initiatives in conjunction with this meeting.

• 4 Parts: denominational resources, organizations, books, research on faith and mental health.

• You can submit resources at: Partnerships@HHS.gov
SAMHSA’S Efforts:

• SAMHSA desires collaboration with the faith-based community.

• Dr. Elinore F. McCance-Katz, M.D., Ph.D., Assistant Secretary for Mental Health and Substance Use, has developed grants to create regionalized Technical Assistance Centers to serve local communities.
SAMHSA Technology Transfer Centers

➢ **Purpose**: develop and strengthen the specialized behavioral healthcare and primary healthcare workforce that provides prevention, treatment and recovery support services for substance use disorders and mental illness.

➢ **Comprised of Three Networks**:

- Addiction Technology Transfer Centers (ATTC)  
  [https://attcnetwork.org](https://attcnetwork.org)

- Mental Health Technology Transfer Centers (MHTTC)  
  [https://mhttcnetwork.org](https://mhttcnetwork.org)

- Prevention Technology Transfer Centers (PTTC)  
  [https://pttcnetwork.org](https://pttcnetwork.org)

Link to All Three TTCs at:  
[https://techtransfercenters.org/landing](https://techtransfercenters.org/landing)
SAMPLE FAITH-BASED TTC TRAININGS:

➢ **Past Events:**

- Engaging the Faith Community in Substance Use Prevention – Parts 1 & 2 – Great Lakes PTTC
- Baltimore Faith-Based Commission (BFBC) Lunch & Learning: Aging, Faith & HIV – Central East ATTC
- Faith & Recovery Conference – Southeast ATTC
- Faith Leaders Listening Session – Southeast ATTC
- Spirituality & Recovery Webinar – Southeast ATTC
- Can We Talk? Interfaith Clergy Behavioral Training – Central East MHTTC
- Faith Communities, Health & Mental Health: Empowering Faith-Based Communities to Help Hispanics and Latinos Overcome Adverse Experiences – Great Lakes MHTTC & National Hispanic & Latino MHTTC
- Conference: “Bridging Secular & Spiritual Communities in Treatment & Recovery – Southeast ATTC

➢ **Upcoming Events:**

- Worldview Dynamics – The Intersection of Culture, Faith, History & Mental Health – Great Lakes PTTC (December 4, 2019)
SAMHSA offers guidance on integrating faith-based leaders into the treatment community with its talking points for faith-based communities: https://store.samhsa.gov/product/PEP14-FAITHLTP:
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Sources:

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3. IBID.

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References Continued:

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**Slide 45:**
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