“Do Not Be Afraid„

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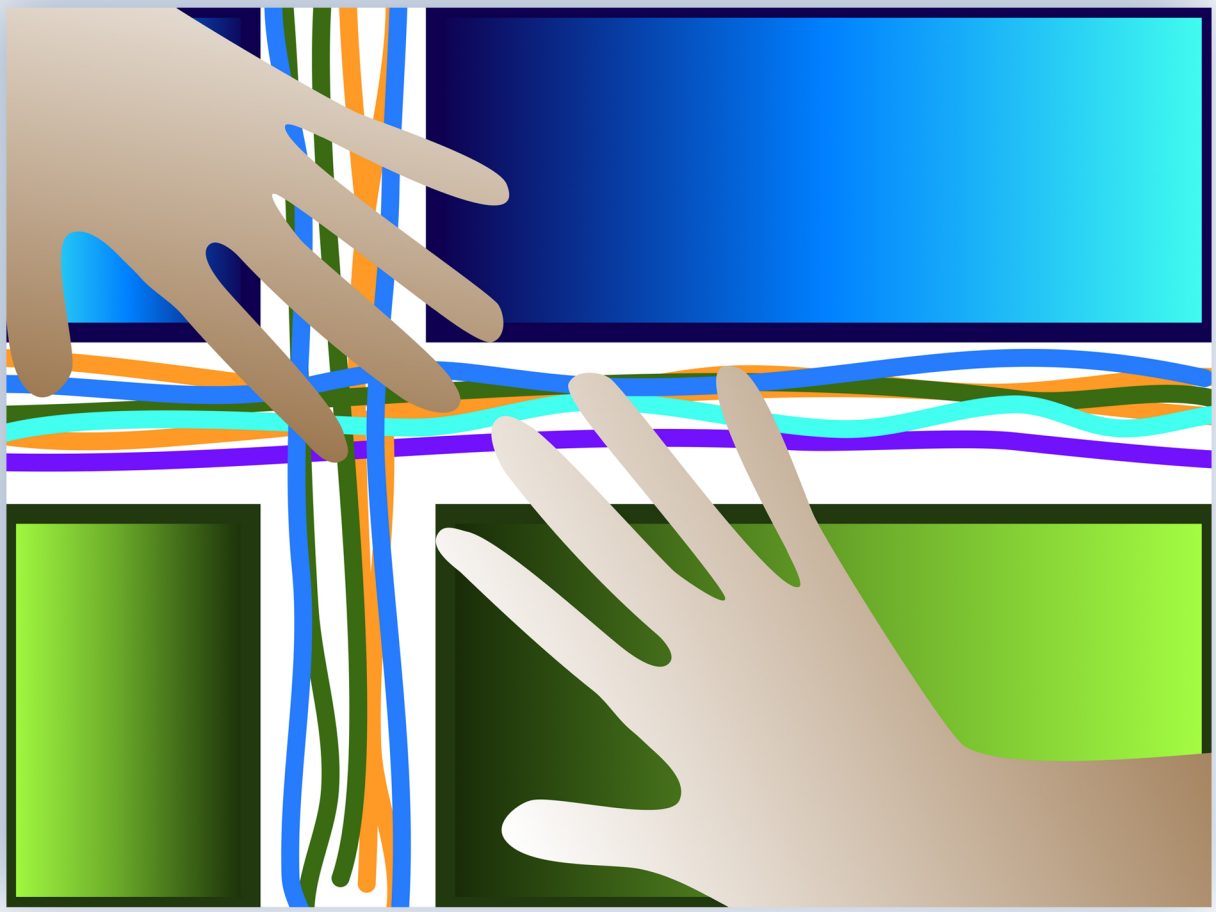

MENTAL ILLNESS AND OUTREACH:
Guidelines for Parishes

“It is important to be able to make people welcome; this is something even more beautiful than any kind of ornament or decoration. I say this because when we are generous in welcoming people and sharing something with them – some food, a place in our homes, our time – not only do we no longer remain poor: we are enriched.”

- Pope Francis (25/07/2013, Varginha)

We acknowledge the Traditional Custodians of country throughout Australia who have walked upon and cared for this land for thousands of years. We pay our respects to Elders past, present and future. We honour and acknowledge the continuing deep spiritual relationship of Aboriginal and Torres Strait Islander Peoples to this country, and commit ourselves to the ongoing journey of reconciliation.

Aboriginal and Torres Strait Islander peoples are respectfully advised that this publication may contain images, names and/or references to those who have passed.

These guidelines have been published by the Australian Catholic Bishops Conference under the guidance of the Bishops Commission for Social Justice – Mission and Service with the assistance of the Australian Catholic Disability Council. With special thanks to Sr Myree Harris RSJ OAM and Associate Professor Paul Fanning.

For more information and resources please contact:

Disability Projects Office

Secretariat for Social Justice -– Mission and Service

Australian Catholic Bishops Conference

GPO Box 368 CANBERRA ACT 2601

ISBN-13: 978-0-909246-26-6

disability@catholic.org.au

02 6201 9868

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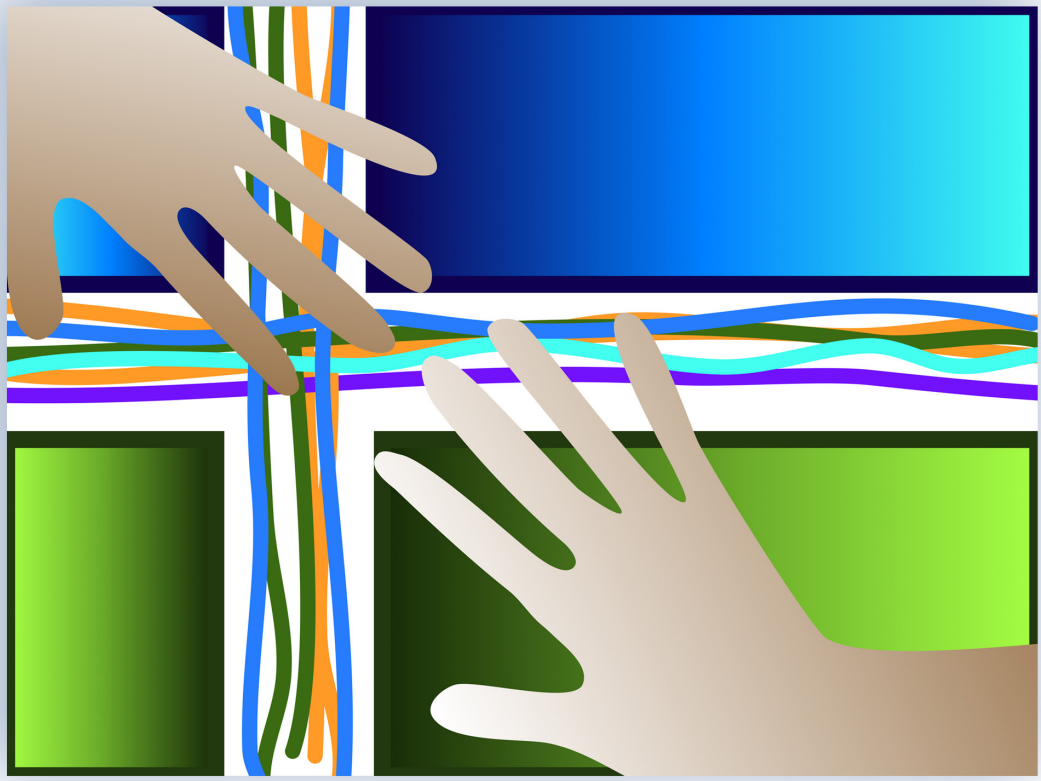

MENTAL ILLNESS AND OUTREACH:
Guidelines for Parishes

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Introductory Statement

One in five Australians will develop mental illness during their lifetime. That means we all know a family member or a friend who is affected. Through high profile people speaking out about their experience of depression and other forms of mental illness, the stigma has lessened. However, for many people it is an unknown area. Modern interventions allow most people with a mental illness to recover and lead a contributing life but these need to be made widely available as treatments for physical health disorders. Understanding and compassion for sufferers but also their carers ensures greater inclusion thereby reducing stigma and discrimination at a community level. This set of resources has been put together to assist parish members to understand people they know or meet who may have metal illness and to feel more confident in responding to them. The parish as a whole may identify ways to help people with mental illness feel more welcome and valued for their gifts and contribution.

Acknowledgement:

This booklet has been adapted with permission for use in Australia from the booklet *'Mental Illness and Faith Community Outreach'* by Deacon Tom Lambert and Rita Lambert (Archdiocese of Chicago, Commission on Mental Illness and Faith and Fellowship for People with Mental Illness).

Dear Friends in Christ,

One in five Australians will experience mental illness this year. When your parish or community gathers, nearly everyone there will know someone who has a mental illness of varying severity and duration. Because of the stigma attached to mental illness, few will come forward; but it is there.

The stigma of mental illness can be as damaging to families and carers as the illness itself. In fact, misconceptions about mental illness often exasperate the condition.

The fact is that at some time, we may suffer a form of mental illness. We may feel depressed or experience anxiety. This may lead to isolation and loneliness.

As Christians, we are called to be welcoming and loving to all. 'We are one body in Christ". As one body, we all experience suffering in one way or another and we look to God for comfort. Pope Francis reassures us that

> *"A God who can enter into the depths of our suffering is not repulsed by our woundedness or disfigurements, but who meets us wherever and whoever we are, heals us by bringing us ever closer to himself."*
>
> *— Pope Francis, A Big Heart Open to God: A Conversation with Pope Francis*

So, if our God can meet us where we are, surely we are called to meet our brothers and sisters suffering with the isolation and loneliness mental illness can sometimes bring.

We are called to provide opportunities to welcome, encounter and embrace our total community as the living body of Christ.

To be authentic, this view must include every member of the community acknowledging their call, their gift and their presence. We cannot claim to be truly disciples of Jesus unless we are totally engaged in honouring His presence in each one and in building and nurturing this community to be a living witness of that presence. Clearly this is a revealed truth that is fundamental to our sense of our own real value. Just as clearly this truth should be so evident in our lived experience that others are drawn to know, understand and experience the Father's love that Jesus reveals.

People living with mental health challenges are no less members of the Body of Christ than anyone else. Obviously there are particular challenges to enabling their full participation in the life of the community. Some of these challenges are visible and many others not so clearly identified. Once we acknowledge these challenges we can work together to ensure that all the gifts that flow through the Body of Christ can be shared by each member of that Body.

Yours sincerely in Jesus,

+ Donald Sproxton
Bishop Delegate for Disability Issues
Bishops Commission for Social Justice — Mission and Service
Australian Catholic Bishops Conference

Foreword

This booklet is intended to be a resource for parishes for ministry to people with mental illness and their families. We thank and acknowledge Deacon Tom Lambert from the Chicago Archdiocese Commission for permitting us to use his words in this preface.

"Parish communities can be of tremendous help - offering hope, unconditional love, and support to people who often find themselves stigmatized and isolated from the community. Persons with a mental illness and their families frequently turn first to clergy for answers to this severe crisis in their lives. The illness can raise profound questions concerning God and faith. The parish response can make a difference in people's reaction to the crisis and their recovery from it. Since society has struggled in its responsibility for adequate care of those who face serious mental illness, it is critical for parish communities to speak for those who often have no voice in the community seeking compassion for those affected and justice for what is rightfully theirs. The parish is called upon not only to reach out to individuals and their families but also to bring about change in the systemic problems facing the mental health delivery system.

Parish communities are like a stained glass window. When we see a stained glass window in a church, we are struck by the beauty of the story it tells. The window usually depicts a story from scripture or an aspect of our faith. Taken as a whole, the window gives a complete picture of a particular story or inspiring moment. When we approach the window and look closely at the art, we see that the window is made up of many pieces of glass. The pieces have different shapes and sizes, some are large and some are tiny. We see that the pieces are made of different colours.

Upon closer inspection, we see that the pieces have flaws in them, some have lines or cracks, other have tiny air bubbles in the glass. But taken together as a whole, the unique pieces, big and small, of various colours, with all their flaws transcend their individuality and come together at the hand of the artist to give a dynamic story of faith.

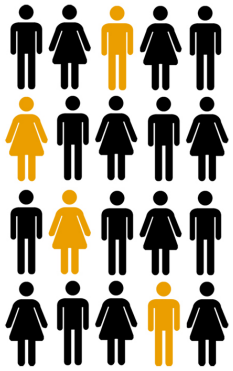
But what happens if part of the window is missing? What if we were to remove all the brown pieces of glass, or remove the large pieces, or the ones with bubbles in them? The picture would be incomplete. We would not get the whole story.

The Body of Christ, the parish community, in one sense, is like a stained glass window. It lives the story of redemption and salvation in the reality of everyday life. The pieces of the story are made up of many kinds and sorts of people - young people, elderly people, married people and single people, people of different backgrounds, people of different shapes and sizes, people who are divorced, people with various disabilities, etc.... Like the stained glass window, the Body of Christ is made up of many parts. If we intentionally or unintentionally exclude, discriminate against or ignore one or more of the parts, we do not get the whole picture. We are missing the full story. The picture is incomplete.

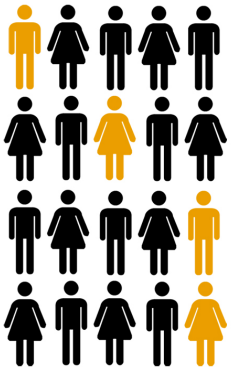
People with mental illnesses are often restricted in their participation in our parishes because the stigma and misperception by society is felt within their own community of faith. Parishes, rather than mirroring the cultural biases of society, should be challenging those assumptions and accepting and reaching out to all people - to open doors and minds to the gifts of all God's people. Parishes that truly welcome and include everyone in a proactive way portray the story of redemption and salvation as a clear and beautiful image of God's Kingdom."

Chicago Archdiocese Commission on Mental Illness

Fast Facts



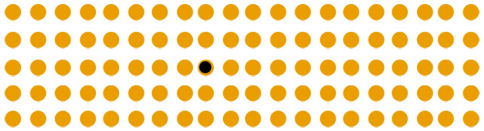
1 in 5 (20%)
Australians aged 16-85 experience a mental illness a year



The onset of mental illness is typically around mid-to-late adolescence

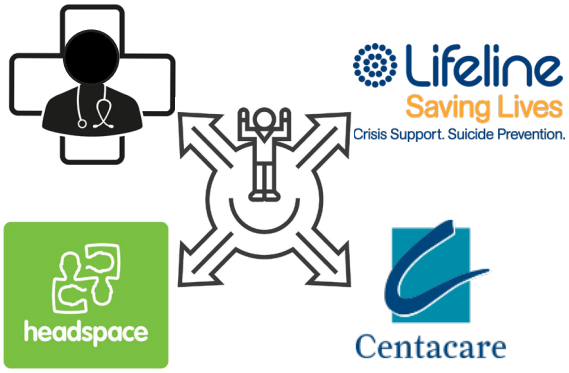
21.2% Australian young people met the criteria for a probable serious mental illness

1% of the population has severe mental illnesses
such as schizophrenia or bi-polar disorder



45% of Australians will experience mental illnesses in their lifetime

54% of people with mental illness in Australia do not access any treatment



The most common mental illnesses are

Depression

6%

Anxiety Disorders

14%

Substance use Disorders

5%

These three types of mental illness often occur in combination. For example, a person with an anxiety disorder could also develop depression, or a person with depression might misuse alcohol or other drugs, in an effort to self-medicate.

Of the 20% of Australians with a mental disorder in any one year...

11.5% have **ONE** disorder

8.5% have **TWO** disorders

Perinatal depression

(depression that was diagnosed from pregnancy to the child's first birthday)

affects 1 in 5 mothers

who were younger, were smokers, came from lower income households, were overweight or had an emergency caesarian section

1 300

Education: What we need to know

DO WE HAVE PEOPLE WITH MENTAL ILLNESS IN OUR PARISH?

Definition of Mental Illness

About one in five Australians will experience a mental illness, and most of us will experience a mental health problem at some time in our lives.

Mental illness is a general term that refers to a group of illnesses, in the same way that heart disease refers to a group of illnesses and disorders affecting the heart.

A mental illness is a health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people. It is diagnosed according to standardised criteria.

The term **mental disorder** is also used to refer to these health problems. A **mental health problem** also interferes with how a person thinks, feels, and behaves, but to a lesser extent than a mental illness. Mental health problems are more common and include the mental ill health that can be experienced temporarily as a reaction to the stresses of life.

Mental health problems are less severe than mental illnesses, but may develop into a mental illness if they are not effectively dealt with.

Mental illnesses cause a great deal of suffering to those experiencing them, as well as their families and friends. Furthermore, these problems appear to be increasing. According to the World Health Organization, depression will be one of the biggest health problems worldwide by the year 2020.

THE FACTS ABOUT MENTAL ILLNESS IN AUSTRALIA

"A society is judged on how its most vulnerable are treated"

In our parishes and communities:

- In each year, one in five Australians will experience a mental Illness
- Mental illnesses are the third leading cause of disability in Australia
- 54% of people with mental illness do not access any treatment
- People unemployed or not in the paid workforce generally have higher rates of mental illness than people who are employed
- Many violent people have no history of mental disorder and most people with mental illness (90%) have no history of violence
- Suicide is the leading cause of death for young people aged 5-17 (2016 data)
- In 2017, 3,128 people in Australia died from intentional self-harm. A high percentage of these people had a diagnosable mental disorder. (2017 data)
- People who experience major mental illnesses such as schizophrenia, bi-polar disorder, major depression, obsessive compulsive disorder, anxiety disorders, personality disorders and other illnesses tend to be isolated and marginalised by society. They and their families often feel excluded from the community they grew up in and from their own parish.
- The myths and misunderstanding of the causes of mental illness keep families from participating in the life of the Church because they feel judged or "different". Often people with mental illness will say that they do not feel valued any

more by their parish or that they are not invited to participate in the life of the Church.

- Parishes need to recognise and address these perceptions, real or imagined. Parishes should include people with mental illness and their families in addressing these issues, as they have insights into the solutions that those not affected can overlook.
- Serious mental illness can cause a crisis of faith for the person with mental illness and their family. Why me/us? How could God do this to me/us? Is God punishing me/us? These and other questions can shake one's faith and be detrimental to recovery. A supportive parish can help work through doubts and questions in a way that leads to recovery and wholeness.
- The need for Church involvement is great. Since the 1960s, the "deinstitutionalisation" of mental hospitals sought to put mental healthcare back into the community. Over the nearly 60 years since, it is well documented that the lack of a commitment and funding to community mental healthcare has created a crisis for those who experience mental illness. Poverty affects many of these people. Even those on the Disability Support Pension find few rental properties affordable, while those on Newstart Allowance find it is almost impossible to pay for shelter, food and other essentials.
- A study, *w*found that 75% of people who were on the streets or in homeless shelters had mental illness and 23% of men and 44% of women on the streets had schizophrenia.
- 40% of people in prisons have mental illness.
- Many people with mental illness are in recovery and are leading contributing lives. Due to the associated stigma, they are unlikely to tell anyone at work or in the neighbourhood that they have a major mental illness. Another group that are able to work sometimes find mental illness debilitating that results in absences from work. Others may never be able to work or can do so only in supported employment.
- The good news is that, for many people, mental illness is treatable and manageable. 70-90% of people receiving the best combination of psychiatric care, medication, community and spiritual support have significant reduction in symptoms and improved quality of life. Unfortunately, people are often reluctant to seek help or treatment because of the stigma society puts on mental illness. Even if people do seek help, they often run into the limitations of an inadequately funded and poorly targeted mental health system.
- Families are affected as well. Lack of adequately funded community mental health teams and crisis teams puts the burden of care back on families. They are often drained physically, emotionally and financially. Families experience feelings of guilt, denial, loss, isolation and hopelessness.
- People living in many rural and remote areas of Australia are often seriously disadvantaged, lacking access to the most basic mental health services due to the absence of local or visiting mental health practitioners, public or private.
- This creates an additional level of complexity and strain for people with mental illness and their carers.
- In a crisis it is not unusual for journeys or ambulance transfers to take place over hundreds of kilometres for assessments to be undertaken and treatment initiated. Ongoing care is also complicated by this situation.
- Local general practitioners, where they are available, in small country towns may undertake the first intervention which can be daunting and time consuming, but critically important.

Telephone access to 1300 or 1800 numbers is no substitute for local and responsive mental health services.

TYPES OF MENTAL ILLNESS

People with mental illness are not a group apart, they are with us all the time and may include close family and friends. Causes of mental illness are multifactorial, but early recognition of at risk people and groups, prevention and early intervention are important for improved outcomes. Improving understanding through education can lead to stigma reduction, thereby facilitating early referra however equally important is personal support, compassion and practical help to people impacted as well as their carers who often feel alone and isolated or even abandoned.

The Most Common Mental Illnesses Are:

Anxiety

People with anxiety disorders may be unable to stop worrying about seemingly unimportant things, and they can perceive situations as much worse than they actually are. Anxiety interferes with the enjoyment of life and disrupts work, relationships and self-perceptions.

Anxiety disorders include:

- **Social anxiety disorders:** also known as social phobia, means social anxiety affects your life and prevents you from participating in everyday social events in your personal or work life.
- **Obsessive Compulsive Disorder:** people with obsessive-compulsive disorder (OCD) experience unwanted negative thoughts that can be constant and can start to take control of their lives. There are two types of symptoms:
    - **obsessions** - an unwanted thought, image or urge that repeatedly comes into the mind
    - **compulsions** - repetitive behaviours or rituals, that are difficult or impossible to resist doing, which are carried out to reduce anxiety
- **General anxiety disorder (GAD)** is a type of anxiety disorder where people have uncontrollable worry that impacts on day-to-day life.
- **Agoraphobia** is often thought to mean that people are afraid of 'open spaces', but this is only half the story. Many people with panic disorder avoid situations because of their fears. This avoidance is known as agoraphobia.
- **Post-traumatic stress disorder (PTSD)** is a treatable anxiety disorder affecting around one million Australians each year. It happens when fear, anxiety and memories of a traumatic event don't go away. The feelings last for a long time and interfere with how people cope with everyday life. PTSD can be caused by traumatic experiences that involve death, serious injury or sexual violence (actual or threatened). This might include physical or sexual assault, living in a war zone, torture, and natural disasters.
- **Panic Attacks:** Panic attack symptoms can strike at any time. They come on very rapidly and usually peak within a few minutes.

  Panic attacks are very common, with up to 40% of Australians experiencing a panic attack at some stage in their life. During a panic episode, someone is overwhelmed and disabled by the physical symptoms listed below. The panic reaches its peak after about 10 minutes and can take up to half an hour to subside. A panic episode leaves the person feeling temporarily exhausted and drained. Symptoms often include:

  - sweating
  - shaking
  - increased heart rate
  - chest pain
  - shortness of breath
  - choking
  - nausea or pain in the stomach
  - dizziness, feeling lightheaded or faint
  - numbness or tingling

- depersonalisation (feeling detached from yourself or your surroundings)
- hot or cold flushes
- fear of dying
- sense of impending doom or danger.

Depression

People with depression can feel sad for weeks on end, find themselves low on energy or motivation, or no longer enjoying doing things that used to interest them. There are many forms of depression including

- **Major depression** - also known as clinical depression or unipolar depression, refers to distinct episodes of depression lasting two weeks or more that have a negative impact on everyday functioning.
- **Melancholia** - a less common and more severe form of depression which causes slowed movements and a complete loss of pleasure in everything.
- **Psychotic depression** - a rare form of depression accompanied by a distorted view of reality, such as delusional thinking (negative and untrue beliefs) and hallucinations (e.g. hearing voices).
- **Antenatal and postnatal depression** - triggered by pregnancy or childbirth. Up to 10% of pregnant women and 16% in the three months after birth will suffer from depression.
- **Cyclothymia** is a chronic disorder with at least two years of alternating periods of low and high moods that are less severe than major depression or mania. It can be described as a mild form of bipolar disorder.
- **Seasonal affective disorder (SAD)** involves periods of depression that occur in particular seasons, particularly winter, and related to low levels of sunlight. This condition is most common in places with long nights in winter, such as those regions closer to the North Pole.

Substance Abuse Disorders

A substance abuse disorder involves using too much alcohol, tobacco or other drugs. It can also be called substance abuse, substance dependence or addiction. Alcohol is the most widely used social drug in Australia. It increases the risk of depression and anxiety and other mental illnesses in some people. Likewise, people with mental health issues are more likely to abuse alcohol than others. Alcohol can make medicine like antidepressants less effective. In the short term, alcohol is a major cause of violence and suicidal behaviour.

Having a mental illness can make someone more likely to abuse drugs to lessen their symptoms and make them feel better in the short term. In other people, drug problems may trigger the first symptoms of mental illness. People with a mental illness experience drug problems at a far higher rate than the general community.

EVERYDAY EXPERIENCES

My hopes are that pressure be put on governments to house people with mental illness in caring communities where medication and food would be provided. Fostering of trained personnel is a big factor.

Psychosis

People with psychosis experience an altered sense of reality. They have difficulty with the way they interpret the world around them, and their thinking can be confused. They may experience hallucinations, such as hearing voices that are not there, or delusions, where they have false beliefs about themselves or the world around them.

Types of psychosis include:

- **Schizophrenia** is a significant mental illness that causes someone to have an altered experience of reality. Schizophrenia affects people's thoughts, perceptions and behaviour and interferes with their ability to function at work, school or relate to other people.
- **Bipolar disorder** is a condition where people experience extreme moods. It was previously known as 'manic depression'. People with bipolar disorder experience periods or 'episodes' of extreme lows, or depression - where they feel very low and lethargic, extreme highs, or mania - where they feel very high and overactive (less severe mania is known as 'hypomania') or severe depression.

Psychosis can occur across the life span from the young to the elderly, requiring complex specialist psychiatric interventions.

This is why medical sub specialisation occurs, hence child, adolescent, adult and old age psychiatrists as well as those who specialise other areas.

Psychosis in its various forms is often treated with particular medications that require strict adherence and close monitoring.

Unfortunately people with psychosis can have a shorter life expectancy so treatment ideally should involve a psychiatrist, GP, mental health nurse and other health professionals.

The intensity and duration of treatment and follow up is variable according to the severity of the psychosis and individual treatment responses, but the vast majority of people respond well to comprehensive treatment approaches.

Secure housing, a healthy diet, work, social support and acceptance are also critical to a good prognosis, recovery and full participation in life.

Sometimes psychosis can occur as a consequence of illicit drug intake where a person loses contact with reality and become a danger to themselves or others. This is a psychiatric emergency requiring a crisis response.

EVERYDAY EXPERIENCES

A young lady with a mental illness who joined a group run by the Sisters of Mercy was referred by the mental health services. She now does volunteer work at a local Catholic Nursing home. She is also delighting in discovering her ability to write in a writer's group which was set up as an offshoot to the depression support group.

THE FACTS ABOUT SUICIDE IN AUSTRALIA

Parish leadership and communities often encounter the reality of day to day living among parishioners and people in the general community. Together we rejoice and together we mourn. Often, people faced with the struggles and hurts of daily living look to their faith communities for support and sometimes answers to their problems.

When there is a spike in the news about natural disasters, where there is an unnatural and sudden loss of lives or the death by suicide of a parishioner or statistics of death by suicide portrayed locally or nationally, people tend to seek answers from their faith communities.

As parishes, we are called and commissioned to offer prayers, to support, show compassion, provide links for networking and counselling, and ways to serve those most in need.

It is critical for parishes to be organised and ready to receive people who might call or visit. Preparation might include a plan of action, list of people on hand to provide support, meals and practical support including telephone contacts and links to professional services.

The following statistics provide a snapshot of suicide in Australia

- Suicide is a prominent public health concern in Australia. In 2017, 3,128 people in Australia died by suicide. (Australian Bureau of Statistics (ABS) Catalogue 3303.0 Cause of Death Australia, 2017 released in September 2018.)

  This is eight people a day. It is more than people who die in motor vehicle accidents or because of skin cancer in a year. Suicide is the leading cause of death for Australians aged between 15 and 44.

- The suicide rate for Aboriginal and Torres Strait Islander Peoples in 2017 (24.9 per 100,000) is more than twice as high as non-indigenous people (12.0 per 100,000). (Australian Bureau of Statistics (ABS) Catalogue 3303.0 Cause of Death Australia, 2017)

Some groups of people are at increased risk of suicide:

- Men

  The highest suicide rate (suicide deaths per 100,000 people) by age of any group is males over 85 years. Three times more males than females die by suicide, although more females than males attempt suicide.

- Aboriginal and Torres Strait Islander people
- People with mental disorders such as major depression, psychotic illnesses and eating disorders, especially after discharge from hospital or when treatmenr has been reduced
- People who have previously attempted suicide
- People bereaved by suicide
- People with alochol or drug abuse problems
- Members of the LGBTQI community
- People who live in rural and remote areas.
- People from culturally and linguistically diverse communities
- The highest suicide rate (suicide deaths per 100,000 people) by age of any group is males over 85 years. Three times more males than females die by suicide, although more females than males attempt suicide.

Risk and Protective Factors

While someone with a number of risk factors may be more likely to attempt suicide, these can be balanced by protective factors. Sometimes risk and protective factors are opposite elements of the same situation. For example, social isolation is a risk factor while social connectedness, whether through family, friends, church or other supportive relationships, is a protective factor.

Resilience

Personal resilience can help people deal with stressful situations.

However people's resilience levels can vary over time, depending on their current life situation. In times of acute stress or distress, resilience levels can be low and the person can find it difficult or impossible to deal with the emotions they are experiencing.

The term 'psychache' describes the overwhelming pain, despair, helplessness, hopelessness, fear, shame and worthlessness people can experience which can lead to thoughts of suicide. People talk about being at the bottom of a black hole with no way out. People experiencing these intense feelings don't necessarily want to die. They just want the terrible pain to end and cannot see any other way out.

Supporting Someone Talking About Suicide.

Warning signs

People having thoughts of suicide will often show warning signs. These can include statements such as:

- 'I'm no use to anyone'
- 'They'd be better off without me'
- 'I can't take any more'

There may also be behavioural changes:

- Social withdrawal
- Change in eating or sleeping patterns
- Risk-taking behaviour
- Increased drug and/or alcohol use
- Putting affairs in order

Helping Someone at Risk of Suicide

If you are concerned that someone is having suicidal thoughts, let them know of your concern. You might want to tell them some of the warning signs you have seen. 'We haven't seen you at football practice for the last few weeks.' The only way to ascertain if they are having thoughts of suicide is to ask. It is important to ask them directly 'Are you having thoughts of suicide?' or 'Are you thinking of taking your life?' Asking this question will not put the idea in someone's head if they are not at risk. It gives the person, who may be feeling ashamed or afraid, permission to talk about what they are feeling.

The next step is to listen, supportively and empathetically. Do not offer advice, try to cheer the person up or make light of what they are feeling. While at other times their resilience may help them deal with what they are experiencing, at this moment their feelings are real and overwhelming.

Let them know that you are there for them. Don't be judgmental, even if you disagree with thoughts they are expressing. If you are not sure what they are saying ask if you can clarify so that you do understand.

Offer your support to help them seek professional halp`. Let them know that you are concerned about them and ask them if they would be willing to seek professional help. Offer your assistance to help them make contact with their preferred healthcare provider.

QUICK TIPS

- It is important to ask them directly 'Are you having thoughts of suicide?' or 'Are you thinking of taking your life?'
- Listen, supportively and empathetically
- Let them know that you are there for them
- Don't be judgmental, even if you disagree with the thoughts they are expressing
- Offer your support to help them seek professional help. Let them know that you are concerned about them and ask them if they would be willing to seek professional help.

Parish Action

- Telephone contact list and links for professional services in a handy spot in parish centre (See Resources for telephone contacts)
- Form a bereavement outreach ministry where:
  - lives of loved ones, including deaths by suicide, are celebrated annually
  - support network (parish/deanery/ diocesan) including people trained in suicide bereavement

EVERYDAY EXPERIENCES

Margaret, a sole parent and her 15 year old daughter, Caitlin, visited their local GP. Margaret was extremely concerned at her daughter's gradual weight loss, preoccupation with her body image, and purging after meals. Over 12 months she had gone from seemingly an outwardly happy, well adjusted, high achieving and popular girl to being withdrawn and obsessed with her computer. The GP referred her to a psychologist who worked in the field of eating disorders. Caitlin responded well to this, her condition improved but after some months she relapsed, lost weight rapidly, wanted to drop out of school and became very anxious. The GP referred her to a teaching hospital multi disciplinary child and adolescent mental health team that initiated a longer term outpatient treatment plan. Caitlin responded well, maintaining a healthy weight gain, less obsessional symptoms and returned to school. Monitoring of her condition will continue for some time.

WHAT DO I SAY? How Do I Talk About Mental Illness?

The words we use matter, especially when speaking about people who are often stigmatised by society through inappropriate or thoughtless use of language.

For people with mental illness, the stigma surrounding the illness, rooted in misconceptions and erroneous beliefs, is compounded by the language and descriptions we use.

As people of compassion, we should never use stigmatising, demeaning language that refers to people as “crazy” or “mental”, “psycho” or “lunatic”.

We should use appropriate language to describe diseases of the brain, and be careful not to misuse terms. For example, schizophrenia is an illness that has symptoms of delusions and hearing voices. It is not having a split personality.

Careful use of language is more than being “politically correct”. It is a way of communicating that people with mental illness, as Pope St John Paul II said, ”have the inalienable right not only to be considered as an image of God and therefore as a person, but also to be treated as such.”

EVERYDAY EXPERIENCES

For many people with a mental illness, it can be impossible to have full and active participation in parish life. They are so tired all the time (from a combination of medication and illness) that they just don’t have an opportunity to venture out much at all. Until recently, this was the case with me. Therefore, what is vital for them is personal contact with a member of the parish. Receiving the Eucharist every Sunday from a Eucharistic minister is vital but what is almost as important is that the Eucharistic minister has a chat with them to see how they’re going on! We can’t afford to feel alone and not part of the church, even though it, at times seems we are! All Eucharistic ministers should be given very basic training in counselling skills! Soon, I am to see a new psychiatrist and as a result, am hoping to see an even bigger improvement in my mental health. If this occurs, I hope to use my high degree of creativity (which is common to a lot of people with mental illness) in the musical area of the parish. I can play the piano by ear even better than by reading music and I can do 6-part harmonies in my head!

INTERACTING WITH PEOPLE WITH MENTAL ILLNESS

People with mental illness have many gifts and talents that add to our life as a community of faith.

The first step in interacting with people with a mental illness is to recognise that each person has dignity.

The next step is to recognise in ourselves any preconceived negative images and prejudices we may have toward people with mental illness. These usually are formed by distorted media images, isolated bad experiences of people with mental illness, or the many myths surrounding mental illness. Once we strip away the generalisations and distortions, we are better able to see a person for whom they truly are, a person created in the image of God.

Each illness carries with it symptoms that may affect how people interact with us and we with them. The intensity and severity of the illness impacts one's ability to communicate. Mental illness can affect a person's ability to think sequentially, to manage emotions or mood swings, and to be in relationship with others.

Someone with depression may seem uninterested or distant. That is a symptom to be recognised but not indicative of the person they are outside the illness. A person with schizophrenia may hear voices or experience hallucinations which are very real to them and is their reality. It is important not to deny that they are experiencing those symptoms but to help them understand it is not what you are experiencing and that you are willing to learn more about what they are going through.

A person who has a panic disorder may be uncomfortable in church or at meetings. So it is important to be sensitive to the person's need for space or need to get up and move around.

In crisis situations, people with a mental illness may exhibit symptoms relative to the intensity of their illness and the treatment they are or are not receiving.

A person exhibiting untreated symptoms of mental illness such as severe depression, schizophrenia, and bi-polar disease may need crisis intervention by trained professionals. Therefore it is important to know the resources available in your area to seek help.

We should act in a safe manner at all times (for example; do not stand over the person, give the person some space, slow down and lower your voice to be less threatening). This is for ourselves and the person to whom we are ministering.

We should not engage the person in arguing or confrontation about the symptoms but rather comfort them and calmly help them to seek treatment.

We are not psycho-therapists who treat the symptoms of mental illness, just as we are not oncologists who discuss remedies for a person with cancer. We are spiritual friends and companions who journey in faith with those who are in need or suffering and who are often isolated by their illness.

EVERYDAY EXPERIENCES

To create a better understanding and awareness of mental illness and its effect on the 'sufferer' and family. Change attitudes. Use the parish bulletin to educate people.

In the recovery model, we are part of the social and/or spiritual component in a person's life. Understanding the symptoms of the particular mental illness of the person will help us to better communicate, minister, advocate, and pray with people with mental illness.

Listening is an important part of interacting with people with mental illness. People's personal stories are sacred. A person's story of suffering and coping with a life changing illness can be a frightening and lonely experience. Often a major mental illness is accompanied by doubts about God and can cause a crisis of faith.

Holy listening, that is, listening in the context of the healing presence of God, means hearing what a person tells us and letting their story unfold. We respond and react to their story in a non-judgmental way with an unconditional love for the person. **Holy listening** allows and encourages people to relate their experiences in a supportive atmosphere that leads to comfort and healing.

Holy listening brings one to a richer understanding of God's unconditional love for us through our acceptance of one another. **Holy listening** leads to a mutuality of understanding that allows the person who is ministering to another to begin to see that they are being ministered to as well. This supportive process leads to solidarity and mutuality that enriches faith and hope. The listener then becomes the learner and both journey the path to wholeness and holiness.

As individuals and as Church we are called to create an environment that sends a message of acceptance that encourages people to tell their story. Such an environment in fact gives a person "permission" to tell their story which they may otherwise feel too uncomfortable or too embarrassed or too stigmatised to tell. This process usually develops over a significant period of time. We need to build trust and a safe place for the person to tell their story. We need to patiently allow the story to unfold

EVERYDAY EXPERIENCES

Harold had schizophrenia and his current medication did not adequately control his symptoms. One day I found him crying in the backyard. "Can't you hear that woman. She is tormenting me and telling me I am worthless". I replied that I couldn't hear her and that it was probably his illness causing the voices in his head. Next morning, as we drove to his appointment with a local psychiatrist, he cried again and said, "Why won't anyone help me?" As we entered the psychiatrist's office, he greeted us: "Good morning. How are you Harold?" With a beaming smile, Harold replied I am very well, Doctor. This medication is doing me the world of good". I exclaimed "Harold, what happened yesterday when the voices tormented you. What about your tears in the car on the way here? " To which Harold replied, "I was just trying to be polite".

In a nutshell!

- Recognise that each person has dignity
- Recognise in ourselves any preconceived negative images and prejudices we may have toward people with mental illnesses
- Separate the illness and symptoms from the person
- In a crisis
  - ... know the resources available in your area to seek help
  - ... comfort the person and calmly help them to seek treatment
- At all times act in a safe manner for ourselves and the person to whome we are ministering.
- We are spiritual friends and companions who journey in faith
- Understand the symptoms of the particular mental illness of the person
- Holy Listening
- Create an accepting and welcoming space where people can tell their story!

EVERYDAY EXPERIENCES

Bernadette presented with her 80 year old husband, Dan, to the emergency department in a large regional city with a referral letter from her GP. They had travelled 300kms from their farm located 26kms outside of a small town. Following a fall off the back of a truck two months earlier Dan had begun experiencing periods of agitation, confusion, memory loss and hearing threatening voices coming from the ceiling. He began sleeping with a loaded shotgun next to their bed. After his army service in the 1960s he had a psychotic episode that was successfully treated with an admission and medication. Since then he had married, raised a family and they had farmed successfully. On this presentation emergency department staff undertook an extensive physical examination including a range of scans which detected no significant abnormality. The decision was made to refer him to a visiting old age psychiatrist, who flew into the city one day a month, but the waiting list was 3 months. Dan and Bernadette returned to their farm, but two weeks later he wandered with his shotgun in a confused state from the farm and needed to be transferred by ambulance back to the regional hospital. This time he was admitted, commenced on stabilising medication and subsequently transferred on again to a referral hospital for comprehensive assessment, admission and treatment by a specialist old age psychiatrist. The entire process took several months, and was both upsetting and dislocating for Bernadette and Dan. Finally he was able to return home on a treatment plan with support provided by the local GP and a monthly visiting mental health nurse.

JUSTICE ISSUES CONCERNING PEOPLE WITH MENTAL ILLNESS

Dignity of the individual

Pope St John Paul II's message to healthcare workers states that " whoever suffers from mental illness "Always bears God's image and likeness in (themselves), as does every human being. In addition, (people with a mental illness) 'always have the inalienable right not only to be considered as an image of God and therefore as a person, but also to be treated as such".

One of the greatest obstacles for people with mental illness and their families is overcoming the stigma the general public associates with mental illness. These misperceptions hinder us from seeing the person as the image of God.

Stigma keeps people from receiving the treatment and care they need for recovery/

- The stigma surrounding mental illness is one of the most significant challenges to the development of effective mental health policy.
- This stigma has intensified over recent decades, despite the advancement of scientific knowledge about the causes of mental illness and the effectiveness of treatments. Many people erroneously still associate mental illness with violence.
- Nearly two thirds of all people with mental illness do not seek treatment. Fifty percent of young people are too embarrassed to ask for help from mental health professionals.
- Stigma pushes people to the margins of our society. People fear what they do not know. The stigma of mental illness exacerbates the misconceptions people have about who the person really is.

Church's Response

As Church, we are called to counter the sinful effects of stigma by:

- Using "people first" language to reinforce the dignity of the person e.g. "people with a mental illness' not "the mentally ill". This allows people with mental illness to be recognised as a person not a disease.
- Recognising that everyone has something to contribute. We value the individual for who they are and what gifts he or she brings to the community.
- Debunking myths and mental illness characterisations that portray people by generalisations that that have no basis in fact and are negative and demeaning.
- Welcoming and including all people into our parish community and treating each person with dignity and respect. Finding ways to proactively include people.
- Educating and informing parish communities about the facts concerning mental illness.

EVERYDAY EXPERIENCES

A parishioner invited me to have a cup of coffee, in which we really shared and got to know each other.

The Need for Informed Advocacy

Another theme of Catholic Social Teaching is our priority for those who are most vulnerable and pushed to the margins of society. A basic moral test for our or any society is how the most vulnerable members are treated. In Australia, there is a widening gap between the rich and poor. We look to the story of the Last Judgement which instructs us to put the needs of the poor and vulnerable first:

> *Lord, When did we see you hungry and feed you, or thirsty and give you to drink? When did we see you a stranger and welcome you, or naked and clothe you? When did we see you ill or in prison, and visit you? And the King will say to them in reply, Amen, I say to you, whatever you did for one of these least brothers of mine, you did it for me (Mt 25: 37-40)*

People with mental illness are over-represented in the homelessness population and in prisons. These people are not able to advocate for themselves.

Areas where advocacy is needed:

- There is a great need for more social and affordable housing. The Housing First approach exemplified by the two models, Common Ground and Pathways, has been shown worldwide to be effective in ending street homelessness. Finland entered into a Government supported Housing First approach, and essentially ended street homelessness in ten years. There is one homeless shelter in the whole country.
- Housing First puts homeless people into secure housing and provides the support to help them sustain tenancy. Common Ground uses a large purpose-built facility to house a mix of formerly homeless people and low-income people, with services on site.
- Pathways uses a scattered site approach with support provided by Assertive Community Treatment teams. Housing and support would also assist people with mental illness who leave prison or are sent there by the Courts a part of diversionary programs. (1) (2) (3)
- Community mental health services are under-funded. Acute Care (Crisis) Teams are few and those that exist are over-stressed and difficult to access. There is no security for the Mental Health budget, with general health being given priority. (4) Multiple senior psychiatrists are planning to leave the Public Health System in NSW this year. (5)

What is Advocacy?

A parish community can become a vital and strong advocate for people living with mental illness and for their families supporting them. This section discusses what advocacy is and how parishes can offer advocacy for people living with mental illness and supporting their families.

Definition

The concept of mental health advocacy has been developed to promote the human rights of persons with mental disorders and to reduce stigma and discrimination. It consists of various actions aimed at changing the major structural and attitudinal barriers to achieving positive mental health outcomes in populations. (Advocacy for Mental Health. Geneva, World Health Organization, 2003 (Mental Health Policy and Service Guidance Package)).

(1) Tsemberis, Sam. Housing First. The Pathways Model to end homelessness for people with Mental Health and Substance use Disorders.Hazelden 2010

(2) Padgett, D. Henwood, F. and Tsemberis, S. Housing First Oxford Uni. Press 2016

(3) Burnes, D. DiLeo, D. Ending Homelessness, Why we Haven't, How we Can. Lynne Rienner Publishers 2016

(4) Australian Medical Association: Statement on Mental Health, January 2018

(5) Aubusson, K. Overburdened Psychiatrists Abandon "Broken" Public System. Sydney Morning Herald and The Age. May 29th 2019.

Advocacy means that you speak up for someone. You may need to advocate for the person you care for to:

- make sure they get information, services or resources
- protect their rights
- make sure they are treated respectfully and professionally by services and staff
- make sure they are not discriminated against

What Do I Do?

You can advocate in person, for example by speaking up during a medical appointment, or by phone, email or letter.

To advocate effectively, it helps to:

- collect information about the problem
- know your rights and the rights of the person you are caring for
- be clear and firm about what you want
- listen carefully to responses and suggestions, and take notes

Getting Help with Advocacy

Some organisations provide advice or help with advocacy. These include:

- Australian Government Department of Health – National Aged Carer Advocacy Program
- Australian Government Department of Social Services – National Disability Advocacy Program
- South Australian Aged Rights Advocacy Service – how to advocate for yourself or others
- Children and Young People with Disability Australia – organisations that provide advocacy

What Can a Parish Do?

Locally

- Be a welcoming, inclusive and hospitable place.
- Educate parish personnel and parishioners about mental illness. Debunk myths, talk about appropriate language and provide training in how to be an advocate.
- Develop a response for emergencies and keep local support information on hand.
- How do we identify people with mental illness in our parish? How do we approach people in a caring and compassionate way? Work with the local Vinnies and collaborate on a welcoming and inclusive best practice strategy.
- Form a mental health team
  - Set up a ministry to support people with mental illness. This could include providing a meal, transport, prayer and friendship during a mental health crisis.
  - Provide a peer support ministry so no one is 'left behind'. Partner trained volunteers to people with mental illness and provide opportunities to meet in prayer and friendship on a weekly/fortnightly basis.
  - Provide prayer, retreats and respite opportunities for families, support workers and friends.

Social Justice Group

- Encourage the social justice ministry or parishioners to be involved in the systemic problems that affect people with mental illness. The failure of the mental health system often to meet the basic needs of people with mental illness and their families is a moral issue for us as Australians (see 'Social Justice Ministry' on page 32)
- Advocacy is needed with political leaders and the legislative process. Mental health care in Australia is seriously underfunded given the level of need. Current budgets need to be protected and routinely audited to ensure funds are allocated and spent exclusively on the provision of clinical mental health services and not for other purposes
- Annual publication of detailed audited

government reports of Local Health District expenditure, service types, staffing levels, locations and the numbers of services provided on an inpatient and community basis would be a good start. Faith Communities can write letters and advocate directly with Local Members to bring about justice.

- Housing and jobs are critical to the recovery process. Advocacy for more social and affordable housing can be done by faith communities. Parishioners who are involved in the housing industry can have an impact on the thinking of their peers. Advocacy for government subsidies for employment and support of people with mental illness can be effective.
- Publicise the issues in the church bulletin or newsletter through a series of short articles on the subject. It is important to have a series of articles rather than one or two. A series keeps the information readable by not giving too much to digest at one time. A series gives the chance to explain the facts, the moral implications, and what we can do as a parish community.

Questions to tackle:

- Is there a dedicated local and regional mental health budget where the funds are protected?
- If so what public mental health clinical services are available locally and how are they accessed?
- Are these services responsive, based in the community and available after hours?
- Are these services sufficient in scope to cover the life span from perinatal to old age?
- Are there sub specialty mental health services for indigenous, transcultural, fly-in fly-out, and LGBTQI?
- Does the local health authority have a detailed evidence based mental health service plan?
- If so does the local health authority publish detailed annual progress reports?
- If so are these available to the public?
- Is there an annual process for community consultation about gaps and emerging needs?
- Is there adequate local crisis accommodation and supported stepped care (a system of delivering and monitoring treatments, so that the most effective yet least resource intensive treatment is deliver to patients first)?
- What partnerships exist between public mental health services and local community organisations?
- Isolation: Are we addressing isolation among our parishioners? How can we ensure people are included? Do we need a 'Call' ministry where volunteers check in with parishioners on a weekly basis?
- Do we know the carers in our parish? How are we supporting them?
- Offer anointing of the sick on a regular basis, and visit people in mental health facilities. Do not forget to visit the families and carers during a crisis!
- Celebrate and acknowledge carers, support workers and friends during Carers Week.

Diocesan

- Be informed about the local scene. What is your State or erritory doing for people with mental illness and their families? Write letters to politicians about social housing, homelessness and medical care of persons with mental illness.
- What is happening at diocesan level? Is there an opportunity to develop a spiritual program for people living with mental illness?
- Network with other parishes, deaneries, or dioceses. Pool resources and share information. What are we doing for people with mental illness and their families?
- Do we celebrate International Mental Health Day as a parish, deanery or diocese?

ADVOCACY GROUPS

Contact groups below for more information and support.

National

- National Mental Health Consumer and Carer Forum (NMHCCF) https://nmhccf.org.au/resources/useful-links

  PO Box 174, Deakin West ACT 2600

  (02) 6285 3100

  NMHCCF@mhaustralia.org

- Mind: https://www.mindaustralia.org.au/about-mind/advocacy

- Caring Fairly: http://www.caringfairly.org.au/

- WellWays: https://www.wellways.org/about-us

- Mental Health Australia

  https://mhaustralia.org/

  ALIA House, 1st Floor, 9-11 Napier Close, Deakin ACT 2600

  PO Box 174, Deakin West ACT 2600

  (02) 6285 3100

  (02) 6285 2166

Tasmania

- Mental Health Advocacy

  1800 005 131 (free call)

  contact@yoursaytas.org

  http://www.advocacytasmania.org.au

- Mental Health Carers Tasmania

  Terry Street, Glenorchy, TAS 7010

  admin@mentalhealthcarerstas.org.au

  03 6228 7448 (South)

Victoria

- Women's Mental Health Network Victoria:

  https://wmhnv.org.au/

  100 Drummond Street, Carlton VIC 3053

  (03) 9663 6733

  admin@wmhnv.org.au

- Victorian Mental Illness Awareness Council:

  https://www.vmiac.org.au/

  Building 1, 22 Aintree Street, Brunswick East, VIC 3057

  (03) 9380 3900

- Tandem: https://www.tandemcarers.org.au/

Queensland

- Queensland Advocacy Incorporated

  Level 2, South Central 43 Peel Street, South Brisbane QLD 4101

  (07) 3844 4200 or 1300 130 582

  qai@qai.org.au

  www.qai.org.au

- Queensland Voice for Mental Health

  Unit 1, 78 Logan Road, Woolloongabba QLD 4102

  (07) 3391 5553

South Australia

- Community Visitor Scheme:

  https://www.sa.gov.au/topics/rights-and-law/rights-and-responsibilities/community-visitor-scheme

  1800 606 302 between 9.00 am and 5.00 pm weekdays

- Disability Rights Advocacy Services:

  http://www.dras.com.au/

New South Wales

- Mental Health Carers NSW(formerly Arafmi NSW)

  Monday to Friday, am to p.m.

  Suite 501, Level 5, 80 William Street, Woolloomooloo NSW 2011

  (02) 9332 0777

  arafmi.admin@arafmi.org

- Carers Connection Line

  1300 554 660

  For information, referrals and support

- BEING Mental Health & Wellbeing Consumer Advisory Group
- The NSW Consumer Advisory Group – Mental Health Inc. (NSWCAG)
- NSW Mental Health Consumer Workers Committee

  Suite 501, Level 5, 80 William Street, Woolloomooloo, NSW 2011

  (02) 9332 0200 or (02) 9339 6066

  info@being.org.au

  info@nswcag.org.au

ACT

- The ACT Disability, Aged and Carer Advocacy Service (ADACAS)

  Unit 14, Weston Community Hub, Corner of Gritten St and Hilder St, WESTON ACT 2611

  PO Box 3167, Weston Creek ACT 2611

  adacas@adacas.org.au

  www.adacas.org.au

  02 6242 5060

  02 6242 5063

  TTY: Call 133 677 (National Relay Service) and ask for 02 6242 5060

  If you need an interpreter please call the Translating and Interpreting Service (TIS) on 131 450.

- **CT Mental Health Consumer Network Inc**

  ACT Mental Health Consumer Network

  Level 2 Room 11 Griffin Centre, 20 Genge Street, Canberra ACT 2601

  (02) 6230 5796

Northern Territory

- Northern Territory Mental Health Coalition

  7/18 Bauhinia Street, Nightcliff Community Centre, Nightcliff NT 0810

  PO BOX 157, Nightcliff NT 0814

  (08) 8948 2246

  eo@ntmhc.org.au

- Mental Illness Fellowship Australia (NT) - (MIFANT)

  (08) 8948 1051

  admin@mifant.org.au

  http://www.mifant.org.au

- Mental Health Association of Central Australia (MHACA)

  (08) 8950 4600

  info@mhaca.org.au

  http://www.mhaca.org.au

- Waltja Tjutangku Palyapayi Aboriginal Corporation - Family Mental Health

  (08) 89534488

  manager@waltja.org.au

  http://www.waltja.org.au

- Wurli-Wurlinjang Health Service - Community Services

  (08) 8972 9100

  wurli@wurli.org.au

  https://www.wurli.org.au/

Western Australia

- Mental Health Advocacy Services:

  https://mhas.wa.gov.au/

Theological Framework

The Bishops Commission for Social Justice – Mission and Service sets forth the following framework as a guide to the Church's ministry for and with people with mental illness.

The framework provides a list of quotes and statements to assist parishes in future pastoral planning.

Definition and Role of the Parish

"The primary mission of a parish is to provide for worship, teaching and pastoral care. At the heart of the parish is the idea of community. The parish is expressed in a community. Its structures and personnel serve the community which, in turn, serves and evangelises the broader society. (Church Administration Handbook. (Extract Chapter 11) Brian Lucas, Peter Slack and William d'Apice)

The essential mission of every Catholic Parish is evangelisation: that is, proclaiming and witnessing to the Good News of the Gospel by enacting the life of Christ, who came "that they may have life to the full" [Jn 10:10]. Four of the basic elements of this mission may be described as:

- **proclaiming** the good news of God's love throughout the world
- **inviting** more and more people into the community of disciples
- **sanctifying** by encouraging the whole community of faith to grow in holiness, especially as a worshipping community through intimate connectedness with the source and summit of the Christian Life, the Eucharist.
- **transforming** the world until justice, love and peace prevail.

(Pastoral Parish Councils in Australia Website Australian Catholic Bishops Conference 2007)

"Human Life is sacred; every person is created in God's image"

Human persons are willed by God; they are imprinted with God's image. Their dignity does not come from the work they do, but from the persons they are. (*St. John Paul II, On the Hundredth Year [Centesimus annus].no. 11*)

Since all people are created in the image of God, their dignity and worth cannot be diminished by any condition, including mental illness.

> *"Whoever suffers from mental illness 'always' bears God's image and likeness in himself, as does every human being In addition, he 'always' has the inalienable right not only to be considered as an image of God and therefore as a person, but also to be treated as such".*

When God turns his gaze on man, the first thing he sees and loves in him is not the deeds he succeeds in doing, but his own image, an image that confers on man the ability to know and love his own Creator, to rule over all earthly creatures and to use them for God's glory (*cf. ibid., n. 12*). And this is why the Church recognises the same dignity in all human beings and the same fundamental value, regardless of any other circumstantial consideration. Therefore regardless too—and this is most important—of the fact that this ability cannot be utilised because impeded by mental illness.

John Paul II Saturday, 30 November, Pontifical Council for Pastoral Assistance to Health-Care Workers 1996

"Suffering is Redemptive when united to Christ"

Suffering is a call to conversion: it reminds us of our frailty and vulnerability.

Pope Francis, March 2015

"We are the Body of Christ"

The great strength of community is the uniqueness and giftedness of each member. The more each person uses their gifts, the stronger the community and the richer the relationships in that community. People are liberated if and when they use their gifts. People are imprisoned when they are prohibited or not enabled to use their gifts. Parishes are communities with great potential to receive and nurture the giftedness of people with disability. The Christian community is one in which all people can claim an equal place and contribute through presence and action.

'I Have a Story' Bishops Commission for Pastoral Life Australian Catholic Bishops Conference 2009

It is everyone's duty to make an active response: our actions must show that mental illness does not create insurmountable distances, nor prevent relations of true Christian charity with those who are its victims. Indeed, it should inspire a particularly attentive attitude towards these people who are fully entitled to belong to the category of the poor to whom the kingdom of heaven belongs (cf. Mt 5:3).

John Paul II Saturday, 30 November, Pontifical Council for Pastoral Assistance to Health-Care Workers 1996

"The Word of God affirms the dignity of all people"

Interpretation of scripture should be consistent with the current understanding of mental illness.

In Sacred Scripture, God speaks to man in a human way. To interpret Scripture correctly, the reader must be attentive to what the human authors truly wanted to affirm, and to what God wanted to reveal to us by their words. In order to discover the sacred authors' intention, the reader must take into account the conditions of their time and culture, the literary genres in use at that time, and the modes of feeling, speaking and narrating then current.

Catechism of the Catholic Church #109,110

Interpretation of scripture should be consistent with the current understanding of mental illness. As always, good pastoral judgment calls for a common sense approach to presenting the Word of God to hearers who have a variety of needs and burdens. The more homilists know their congregation, the better equipped they will be to help the people who are thirsting for the word of God.

EVERYDAY EXPERIENCES

I want to be accepted and treated as a normal person by the parishioners and the parish. I want people to talk to me after church.

EVERYDAY EXPERIENCES

Mental illness is of its nature isolating. Church communities are not always welcoming to people with mental illness.

Action! What can Parishes Do?

Parishes are communities with great potential to receive and nurture the giftedness of all its members. The Parish Community must be assisted to welcome people with mental illness and their families and value the gifts they bring and the contributions they can make.

Here are some ideas to try :

DIGNITY OF ALL

Promote the dignity of the individual. God loves each of us as we are. Use "people first" language e.g. phrases like "people with mental illnesses rather than "the mentally ill". No one wants to be known as a disease.

> **PARISH ACTION:** Instruct, inform and educate parishioners, clergy and leadership in the importance of the dignity of each person. Encourage, model and promote 'people first' language.

MENTAL HEALTH AWARENESS TRAINING

Provide awareness training for clergy, members of the pastoral team and parishioners on the misconceptions and misunderstandings they may have about mental illness. Education and training about the facts of mental illness can assist in this.

- An example of this is Mental Health First Aid. This provides short courses that can be a good foundation. https://mhfa.com.au/
- The Black Dog Institute has resources. https://www.blackdoginstitute.org.au/
- Another example is The Compeer Friendship Program, sponsored by the St Vincent de Paul Society screens, trains and supports volunteers who are linked to a person with mental illness for the purpose of friendship. Friends are referred by their mental health professional, who remains involved for support. There is a commitment to regular meetings for enjoyable activities. St Vincent de Paul Society in your local area can be contacted to see if Compeer is available.

> **PARISH ACTION:** Check out Mental Health First Aid Australia (https://mhfa.com.au/), Compeer Friendship Programs NSW and Black Dog Institute.

ENGAGE SPEAKERS

Many organisations and groups are looking for speakers and topics for their meetings. The topic of mental illness could be encouraged. Speakers could be from the medical community, mental health field or advocacy groups. It is important to check out in advance what the speakers have to say on the subject as there is a lot of misinformation about mental illness.

> **PARISH ACTION:** Do we have medical and community experts in our parish?
>
> Invite medical and community experts to address the parish. Host speakers, workshops and educational events for people with mental illness and families/carers of people with mental illness.

INITIAL CONTACT

People with mental illness and their families may make contact with their local parish when a family member first experiences mental illness. It can be important for key parish personnel to know the mental health resources in their area. A start would be to know the phone number of the local Community Mental Health Team. It is important to stay in touch after suggesting such a referral, to provide faith support.

> **PARISH ACTION:** Does the parish have access to mental health services in our area? (See Mental Health Services section)

Where will the parish keep these contact numbers?

How will the parish respond in an emergency? (See Emergency Fact Sheet)

PEER TO PEER MINISTRY

Peer to Peer ministry is an important outreach for people living with major mental illness. People with mental illness often do not have a circle of friends who care for them. A peer is not a professional but a person who is caring and able to be a good listener.

PARISH ACTION: Contact Compeer Friendship Program or start your own group.

CARERS

'Whether it be family or friends, the role of carers for people with mental illness is often not recognised or properly understood. The diagnosis of a mental illness in a loved one can be confusing, frightening and further complicated by stigma and a lack of ready access to professional support. Carers of people with long term serious mental illness are under enormous pressure and more likely to suffer from physical and psychological problems themselves due to this stress. They are often placed in situations where a family member with mental illness may resist advocacy and intervention on their behalf and dealing with the enormously overstretched public health system to seek help can sometimes prove frustrating and disappointing.

Important legislative safeguards that protect the legal and human rights of a person with mental illness may also restrict the roles of carers including their right to information where a patient is hospitalised and seen as unable to give informed consent. In these situations making an appointment with a psychiatric social worker to explain 'the system' is a worthwhile investment in ensuring involvement in the treatment process, particularly when the carers will be required to provide support upon discharge. Carers therefore need ongoing contact where possible with the treatment team and knowing who to call if a care plan is not going well.

Access to opportunities to share their worries and concerns with family, friends and others in the same situation is also critical to carer welfare. Parishes can play a key role in providing this ongoing personal support. The children of a person with a serious mental illness are particularly vulnerable and require dedicated support from health professionals but also understanding and practical support from their schools and parishes. Entire families can be thrown into a crisis when a parent or sibling is impacted by serious mental illness. For children and young people this can be a frightening and uncertain time that can cause significant immediate and ongoing trauma. Sensitive age appropriate and targeted interventions can make a huge difference to long term outcomes.

PEER SUPPORT

For people experiencing mental illness, contact with others who have a similar lived experience can be enormously useful in providing advice about what to expect and clear proof that recovery is possible. Peers can also explain the treatment journey in a way that is different to mental health professionals. Having lived through and with mental illness provides unique insights into the journey to recovery. Peer support workers in professional settings are increasingly critically important members of the treatment team and can help dispel many of the fears of patients. Within community settings such as a parish there are bound to be parishioners with lived experience of mental illness who may be prepared to provide assistance to others. Wonderful training programs are available to improve awareness, understanding and practical tips. These include courses on Mental

Health First Aid, Trauma Informed Care and Mental Health Connect. The remarkable St Vincent de Paul 'Compeer' is evidence based, supported by training programs and a proven track record'.

LONELINESS

'Within the western world loneliness has been identified as a major social concern which seems paradoxical given the explosion in communication technologies, social media etc. While of itself loneliness is not a mental illness it can be a factor in people feeling isolated, unknown and alone. The increasing tendency for people to work remotely and not part of a populated 'social' work environment has positive and negative elements. High rates of unemployment and underemployment are removing opportunities for contact. As many professions and jobs change or become redundant in response to economic and technological changes this situation will accelerate. The impact on individuals, families and entire communities will be significant with add on consequences for people with illnesses and disabilities. Society needs to fully understand the implications and explore opportunities for greater social connectedness.

PRAYER

Incorporate into intercessory prayer at Masses specific prayers for those living with schizophrenia, bi-polar disorder, anxiety disorders etc. This lets the Parish Community know that the community prays and cares for people with mental illness. The prayer sends a welcoming message to those who experience mental illness and their family members that the community supports them.

Healing prayer and services e.g. Sacrament of the Anointing of the Sick should include mental illnesses. This signals to the Parish Community that all forms of illness is in its faith and concern. There is a history of misguided prayer in the past. Mental illness is not a demon possession or a cross to bear or a sign God does not love us. It is just like any other illness. The healing prayer should reflect the biological nature of the illness, other illness. We should pray for healing and provision of sound medical practice.

> **PARISH ACTION:** Do we have access to examples of intercessory prayers? (See Prayers of the Faithful section)
>
> Do we have appropriate liturgies suited to people with mental illness and carers?
>
> Do we have a bereavement group? Do we celebrate/remember people who have died by suicide?
>
> Do we offer Anointing of the Sick to people with mental illness and their families?

HOMILY IDEAS

Preach on the subject. Use Gospel stories to show how Jesus responded to people who were described in those days as being possessed; How he restored the young man called a Demoniac, and the apostles found them sitting together, with the youth fully clothed and in his right senses.

Include references to people with mental illness and their issues in homilies about social justice, caring for the poor, discrimination and compassionate outreach to others. Avoid words or phrases in all sermons and communications that stigmatise those who have mental illness.

Australian Catholic 2019: https://www.australiancatholics.com.au/current/aust-catholic-magazine

HOSPITAL VISITATION

Let parishioners know that their leaders and/or ministers want to visit people with mental illness when they are hospitalised. A hospitalisation for mental illness is a traumatic time for the person and their family. It is an important time for ministerial presence. As for any major disease, the individual and family will have questions about God, faith and "why me?" Ministerial presence and support will help them to understand and accept that this disease of the brain is not a punishment from God

and not due to lack of faith.

PARISH ACTION: How will the parish be informed when a parishioner is hospitalised?

How do we, as a parish, support the person and their family?

- **NETWORK WITH OTHER FAITH COMMUNITIES**

Network with other faith communities in your area and have an annual liturgical celebration of the lives of people with mental illness, their families and mental health workers/professionals. This gathering should be celebratory and positive with a meal or refreshment afterwards for conversation and fellowship.

PARISH ACTION: Meet with other faith communities, share resources and hold combined events or ministries. A bereavement ministry might be considered to remember people who have died by suicide, families recovery from a death of a family/friend by suicide

EVERYDAY EXPERIENCES

Some years ago, a case worker from the Mobile Assertive treatment team in Camperdown told me of her concern about the poverty, loneliness and hunger of her clients at Christmas. She was so worried about them that she bought a case of mangoes and gave one to each person as she visited. She wanted them to have something to wake up to on Christmas Day. This prompted Gethsemane Community to prepare gift hampers consisting of enough basic food for three days, festive food, a range of toiletries, a calendar to record appointments and a gift pack. In 2018, we packed 400 of these. Each year, the numbers increase. Gethsemane Community Inc has a Christmas Project that reaches 1200 people with disabilities.

More information is on the website www.gethsemanecommunity.org.au

What to Do in a Crisis

If you think you or your loved one is in danger ring 000.

Explain to the operator that the person has a mental illness and is in a crisis and you need help.

Overwhelmingly, involvement and support to people with mental illness will be without incident and mutually beneficial at a number of levels.

Occasionally, a mental health crisis can occur without warning, sometimes, but not always, when interacting with previously unknown people who have a history of serious mental illness and/or coexisting drug disorders.

The individual in question may not have been in contact with specialised mental health services or is known to services but not receiving follow up.

A crisis may involve high levels of arousal, a threat of self-harm or harm to others but also confusion or delirium where poor physical health may be an additional concern.

Sometimes a mental health crisis can occur in people without a known history but who have become seriously unwell and needs specialised care.

As non-mental health professionals, it is important to seek immediate support with due regard to personal safety and the welfare of others. Urgent referral is critically important.

After a confronting mental health crisis, it is most important to be able to discuss the incident with members of the parish leadership team or, if necessary, experts in the area.

If you think someone is having a crisis, support them by:

- Keeping your voice calm
- Avoiding overreacting
- Not making promises you cannot keep! For example: promising not to tell anyone else, and promising to always be here for the person.
- Listening to the person
- Not arguing or trying to reason with the person
- Expressing support and concern
- Avoiding continuous eye contact
- Asking how you can help
- Keeping stimulation level low
- Moving slowly
- Not standing over the person
- Offering options instead of trying to take control
- Avoiding touching the person unless you ask permission
- Being patient
- Gently announcing actions before initiating them
- Giving the person space

If you haven't been able to defuse the crisis, then ring a mental health professional.

Crisis support lines 24/7

Lifeline ***13 11 14***
Suicide Call Back Service
1300 659 467
Kids Helpline ***1800 55 1800***

Mens Line Australia
1300 78 99 78
Family Drug Support
1300 368 186

Mental Health Services

Emergency contact numbers

In an emergency, please call **000** or go to a hospital emergency department, where they may refer you to a mental health and/or drug and alcohol service.

Crisis support lines

If you need immediate help in regard to a crisis in health or living circumstances, the following helplines provide telephone crisis support and counselling 24 hours a day, 7 days a week and online assistance (limited hours, depending on the service):

Veterans and Veterans Families Counselling Service

In support of veterans and their families exposed to military mental health

1800 011 046

Lifeline

A crisis support and suicide prevention service for all Australians.

13 11 14 **www.lifeline.org.au**

Suicide Call Back Service

A free service for people who are suicidal, caring for someone who is suicidal, bereaved by suicide or are health professionals supporting people affected by suicide.

1300 659 467 **www.suicidecallbackservice.org.au**

Kids Help Line

A counselling service specifically for young people aged between 5 and 25.

1800 55 1800 **www.kidshelpline.com.au**

STATE CRISIS NUMBERS

In an emergency where there is a risk to life or personal safety you should call 000.

Australian Capital Territory – Mental Health Triage Service

1800 629 354

NSW – Mental Health Line

1800 011 511

Northern Territory – Mental Health Line

1800 682 288

Queensland – 13 HEALTH

13 43 25 84

South Australia – Mental Health Assessment and Crisis Intervention Service

13 14 65

Tasmania – Mental Health Services Helpline

1800 332 388

Victoria – Suicide Help Line

1300 651 251

Western Australia – Mental Health Emergency Response Line

1800 676 822 (Peel Region)

1300 555 788 (Metro)

Social Justice Ministry

Give the social justice ministry the opportunity to be involved in the systemic problems that affect people with mental illness. The failure of the mental health system often to meet the basic needs of people with mental illness and their families is a moral issue for us as Australians. Community Mental Health Teams are often under-funded and can only provide inadequate or incomplete services. Many 24 hour Crisis Teams have been disbanded. Rural areas are very poorly serviced. Police receive inadequate training to deal with people with mental illness who are in crisis and present as threatening. There have been far too many fatal shootings by police of people with mental illness.

- **Advocacy i**s needed with political leaders and the legislative process. The mental health budget must be quarantined from being siphoned off by general health. There needs to be comprehensive planning and targeting of funding for mental health services. Faith Communities can write letters and advocate directly with Local Members to bring about justice.
- **Housing and jobs** are critical to the recovery process. Advocacy for more social and affordable housing can be done by Faith Communities. Parishioners who are involved in the housing industry can have an impact on the thinking of their peers. Advocacy for Government subsidies for employment and support of people with mental illness can be effective.

Form a Social Justice Team in Your Parish

How to set up a Social Justice Group in your parish

Justice and Peace Office: Sydney Archdiocese" http://justiceandpeace.org.au/wp-content/uploads/2015/06/Justice-Peace-Office-Ministry-Resource-2015.pdf

Starting or Reinvigorating a Social Justice Group in your parish: http://justiceandpeace.org.au/home/resources/social-justice-groups-resources/

For more information, please see:

Australian Catholics -Social Justice: https://www.australiancatholics.com.au/article.aspx?aeid=39257

Australian Catholic Social Justice Council: Links for social justice groups: https://www.socialjustice.catholic.org.au/

Micah: Advocacy Resources: http://www.micahaustralia.org/advocacy_resources

Resources

How to Use the Articles and Fact Sheets

The articles and factsheets can be used in the following ways:

- Publicise advocacy issues in the church bulletin or newsletter through a series of short articles on the subject. It is important to have a series of articles rather than one or two. A series keeps the information readable by not giving too much to digest at one time. A series gives the chance to explain the facts, the moral implications, and what we, as a parish community, can do.
- Use the articles and fact sheets for education and training of parish leadership
- Use the PowerPoint slides available here for World Mental Health before or during Mass

SAMPLE ARTICLES FOR BULLETINS AND NEWSLETTERS

It is recommended that the following be introduced with an article from the Parish Priest asking the parish to be aware and involved at some level in outreach to people with a mental illness and their families.

After each article, a contact person within the parish could be identified for people who want further information.

EVERYDAY EXPERIENCES

John had been diagnosed with schizo-affective disorder in addition to intellectual disability. At his first appointment with a new Psychiatric Registrar, the Doctor decided John did not have mental illness after all, and took him off all psychotropic medication. Over successive weeks, John became withdrawn, remained in bed most of the day, refused to shower and shave and began harassing other residents of the community house. A psychiatric nurse at the local health centre arranged for him to be assessed and then admitted to a respite house for people with mental illness. Once there, he was once again put on psychotropic medication and began to improve. After a month, John returned much happier and more stable. His hygiene had improved and he was willing to do some household chores and engage in activities organised by the Mental Health team

WEEK 1: MENTAL ILLNESS IN AUSTRALIA

One in five (20%) of Australians aged 16-85 experience a mental illness in any year.

The most common mental illnesses are depressive, anxiety and substance use disorder. Depression affects 6% of people, anxiety disorders 14% and substance use disorders 5%. These three types of mental illness often occur in combination. For example, a person with an anxiety disorder could also develop depression, or a person with depression might misuse alcohol or other drugs, in an effort to self-medicate.

Of the 20% of Australians with a mental disorder in any one year, 11.5% have one disorder and 8.5% have two or more disorders. 1% of the population has severe mental illnesses such as schizophrenia and bi-polar disorder Almost half (45%) of Australians will experience a mental illness in their lifetime. (1)

The onset of mental illness is typically around mid-to-late adolescence. One in five (21.2%) of Australian young people met the criteria for a probable serious mental illness. (2)

Up to 1 in 10 women and 1 in 20 men struggle with antenatal depression. More than 1 in 7 new mums and up to 1 in 10 new dads experience postnatal depression." .(3)

54% of people with mental illness in Australia do not access any treatment. (4)

(1) Australian Bureau of Statistics (2009). National Survey of Mental Health and Wellbeing. Summary of Results 4326.0 2007 ABS Canberra

(2) Ivancic, L., Perrens, B., Fildes, J., Perry, Y and Christensen, H., Youth Mental Health Report 2014. Mission Australia and Black Dog Institute, Sydney.

(3) Deloitte Access Economics. The cost of perinatal depression in Australia Report. Post and Antenatal Depression Association 2012.

Paulson, J. F. & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its association with maternal depression: A meta-analysis. JAMA, 303(19), 1961-1969. (doi:10.1001/jama.2010.605)

(4) Australian Institute of Health and Welfare. Australia's Health (2014) AIHW Canberra

WEEK 2: MENTAL ILLNESS IN ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Depression.

Among Aboriginal and Torres Strait Islander men, severe mood disorders are about 1.2 times the rate of the general population, while among women it is the same as the general rate. (1) However, there are geographic differences, with 2.5% for Mornington Island, 6% for Bourke and 1% for the Kimberley. (2)

A survey of Aboriginal people attending a community health service in Victoria showed that 54% were suffering from psychiatric illness and that depression was the most common form (3). Another community survey showed high levels of anxiety and depression among this population, with a rate of 50% being three times higher than for other Australians.(4)

Anxiety

Community surveys show rates of anxiety of 1.5% on Mornington Island, 1% in the Kimberley and 5% in Bourke. The Western Australian Child Health Survey showed that up to one quarter of surveyed children aged 4-17 may be at risk of developing behavioural disorders associated with anxiety conditions (5)

Psychosis

The experience of psychosis in traditional Aboriginal and Torres Strait Islander culture was likely to be rare. Tribal people in central Australia have a rate of schizophrenia of 0.4%. (6) This contrasts with the high rate of psychosis currently affecting this population. Aboriginal and Torres Strait islander men are admitted to hospital with mental disorders due to psychoactive substance misuse up to 4.5% higher than the general Australian population. Among women it was 3.3%. The same population had admission rates for schizophrenia at 2.7 times the expected rate and among women it was 2.5 times.

Psychosis in the context of substance abuse is a significant issue for the Aboriginal and Torres Strait Islander population at present.

One opinion is that mental illness was present in Aboriginal and Torres Strait Islander culture prior to European colonization of Australia, but was probably a fairly rare occurrence. The much greater prevalence of mental illness in the Aboriginal and Torres Strait islander population currently is a reflection of the significant disruption to Aboriginal and Torres Strait Islander society and consequent social and emotional deprivation. Management of mental illness requires a strong emphasis on cultural safety, along with the recognition of family, culture and community in any healing process. (7)

(1) Pink, B, Allbon, P, The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008. Canberra. Australian Bureau of Statistics

(2) Hunter, E. Mental Health in Thompson, N editor: The Health of Indigenous Australians. Melbourne. Oxford University Press 2003.

(3) McKendrick,j, Cutterm, T, Mac Kenzie, A., Chiu, E, The pattern of psychiatric morbidity in a Victorian urban Aboriginal general practice population. The Australian and New Zealand Journal of Psychiatry. 1992: 26; 40-7

(4) Jorm, A, Bouchier, SJ, Cvetkovski S, Stewart, G, Mental Health of Indigenous Australians; a review of findings from community surveys. Medical Journal of Australia 2012: 196: 118-121

(5) Zubrick,SR, Silburn, SR, Lawrence DM, Motrou, FG, Dalby, RB, Blair RB et al, The West Australian Aboriginal Child Health Survey. Curtin University of Technology and Telethon Institute for Child Health Research 2005

(6) Kidson, M, Jones, I, Psychiatric Disorders among Aborigines of the Australian Western Desert. Archives of general psychiatry. 1968: 19: 413-17

(7) Parker, R., and Milroy, H., Mental Illness in Aboriginal and Torres Strait Islander People, Working Together 2010 telethonkids.org.au Chapter 7.

WEEK 3: MENTAL ILLNESS AMONG PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

The principal ethnic backgrounds of Australia's population are: British 67.4%, Irish 8.7%, Italian 3.8%, German 3.7%, Chinese 3.6%, Aboriginal Australian 3%, Indian 1.7%, Greek 1.6%, Dutch 1.2%, Other 5.3% (1) 200 languages are spoken. Australia is also a home to refugees who often have a unique and traumatic experience of migration.

People from culturally and linguistic civerse (CALD) backgrounds are less likely to access mental health services. There is a marked reluctance among many from these backgrounds to voluntarily access both hospital and community-based mental health services. (2) This is related to difficulties in understanding and accessing general systems of care and lack of services that are culturally safe and appropriate.

Stigma, lack of information about mental illness and mental health services, lack of services that are appropriate and accessible, poor communication and cultural differences between clients and clinicians are major barriers. This prevents early intervention and ongoing partnerships with service providers. This can result in people from CALD groups being over-represented among involuntary admissions to psychiatric hospitals and in gaols.

Stigma had a particularly strong impact in some cultures and is a barrier to early and effective access to services. The importance of privacy is stronger in some cultural groups than others.

The role of families is of primary importance in many CALD groups. In many transcultural contexts it is the family, rather than the individual, that must be the focus of interventions to encourage awareness of mental health and access to the range of supports that may be needed.

Involving consumers, carers and communities is made more difficult by the shortage of consumers and carers able to be advocates and educators in mental health. Additional supports need to be put in place to address the challenges of the great diversity of community groups and languages, diverse feelings about participation and discrimination about mental health.

The role of the GP is critical for this group. Specific skills are needed by them, such as the ability to work with interpreters and being aware of verbal and non-verbal communication differences (3)

(1) Worldatlas.com

(2) Mc Donald & Steel 1997 Pathways to Recovery: Preventing Further episodes of Mental Illness, Dept. of Health, Australia

(3) People from Culturally and Linguistically Diverse Backgrounds, Pathways of Recovery: Preventing Further Episodes of Mental Illness. Dept. of Health 2006. Internet Publications.

WEEK 4: DUAL DIAGNOSIS OF MENTAL ILLNESS AND SUBSTANCE ABUSE

Up to half the people with mental illness have a co-occurring substance abuse issue. Often this begins with self-medication, to alleviate the distressing symptoms of the illness. Then the two issues interact and compound the problem.

There is international consensus that the best treatment is an integrated approach; where the clinician or team has skills in treatment of both conditions and addresses them together. The concept of readiness for change and stages of change (1) is often key to the effectiveness of this approach. Gradually, mental health and drug and alcohol systems and services are becoming integrated in Australia, but we lag well behind the best services in North America and the United Kingdom. Services with clinicians and teams trained in both areas of treatment are still rare. (2)

Mental illness encompasses biological, psychological, social and spiritual dimensions of the person affected. The illness also impacts the lives of the person's family. Severe mental illness often raises profound questions of faith, such as why does God allow sickness and why me? As a parish, we are called to support individuals and their families through their time of crisis when the illness first occurs and the ensuing life with and recovery from it. The spiritual dimension is critical to the recovery process. We can offer spiritual support through our prayerful presence in people's lives by acknowledging their pain and supporting them through the healing and recovery process.

(1) Prochaska, J., Norcross, J., and Diclemente, C., Changing for Good: A revolutionary six-stage program for overcoming bad habits and moving your life positively forward. Harper Collins 1994

(2) Harris, MA, Models of Treatment for Dual Diagnosis of Mental Illness and Substance Abuse in Canada, USA and England, with an emphasis on the treatment of homeless people. Winston Churchill Memorial Trust website. 2003.

WEEK 5: STIGMA AND MENTAL ILLNESS

Many people with mental illness are in recovery and lead normal lives. Due to the stigma associated with mental illness, you and I are probably not aware of their illness. They are not likely to tell anyone at work or in the neighbourhood that they have a mental illness.

Others with mental illness are able to work but at times find the illness debilitating. Unless their employer is understanding and accepting of their situation, their job may be at risk.

Others will never be able to work and rely on a Disability Support Pension to help them through their lives. Still others may find themselves in a constant cycle of crisis, trying to subsist on Newstart, struggling to pay rent and buy food and obtain adequate help for their mental illness.

As a parish, we can make a difference in people's lives by being accepting of their illness, comforting them in time of crisis, supporting them when needed and assisting them to obtain good health care.

WEEK 6: DEINSTITUTIONALISATION

In New South Wales, deinstitutionalisation, or movement of people with mental illness out of the old psychiatric hospitals, began in the 1960's, and continued through the 1970s and early '80s. (1)The Richmond Report in 1983 (2) provided the vision, that people with mental illness would be integrated into the community and that mental health services would be available there to support them. However, by the time of the Burdekin Report in 1993, (3) it became clear that the money did not follow the former patients into the community. Social and affordable housing was not available for them, nor were the mental health services to support them. Some former clinical staff of psychiatric hospitals saw an opportunity to make a lot of money, and set up private for-profit boarding houses in large facilities. In New South Wales, these were clustered in the Inner West of Sydney, in the Blue Mountains, around Lake Macquarie and in the Hunter Valley. Whole wards of the former psychiatric hospitals were transferred to these places. In 1998, there were 2,175 people with mental illness and intellectual disability in over 200 such places. In NSW it was not until 1998 that a Boarding House Reform package (4) was passed by State Parliament that provided 24 hour care in group homes for the highest level needs people and services to those remaining in licensed boarding houses. It took until 2012 for the Boarding Houses Act (5) to provide legislative protection for the human rights of these people. No doubt, this situation was repeated in other Terrioties. People with mental illness are overrepresented in the homeless population (6) and in gaols. (7)

(1) Mental Health Crisis. A Discussion paper prepared by the St Vincent de Paul Society 1995

(2) Richmond, David The report of the Enquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled. Mental Health Commission NSW. 2019 Re-released pdf version.

(3) Burdekin, Brian Human Rights and Mental Illness. Vols 1 and 2 Aust Govt Publishing 1993.

(4) Hansard NSW Parliament October 15th 1998

(5) Hansard NSW Parliament: October 18th 2012.

(6) Hodder, T, Teeson, M, Burich, N Down and Out in Sydney: the Prevalence of Mental Disorders, Disability and Health Service use Among Homeless people in Inner Sydney. Sydney City Mission 1998.

(7) Mental Health Council of Australia Media Release 2010

WEEK 7: HOMELESSNESS AND MENTAL ILLNESS

75% of homeless people have a mental illness.

Of these, 46% of women and 23% of men have schizophrenia.

33% have a major mood disorder.

48% of women and 28% of men have depression and 26% live with an anxiety disorder.

93% of homeless people in inner Sydney have experienced trauma.

Some of the most disturbing findings were that

- 58% of all homeless people had been seriously physically attacked or assaulted,
- 55% had witnessed someone being badly injured or killed.
- 68% of women had been sexually assaulted. (1)

These statistics show how important it is to advocate with State and Federal governments for safe, secure and affordable housing and support to end street homelessness.

(1) Hodder, T, Teeson, M, Burich, N Down and Out in Sydney: the Prevalence of Mental Disorders, Disability and Health Service use Among Homeless people in Inner Sydney. Sydney City Mission 1998.

WEEK 8: PRISONS AND MENTAL ILLNESS

Up to 80% of inmates in Australian prisons have a mental illness and magistrates in regional areas are sending people with a mental illness to gaol as there is often no treatment or mental health facility available. (1)

One in four prisoners receive medication for mental illness while in prison. 49% of all people entering prison had been told by a health professional that they had a mental health disorder and 27% were on medication. (2)

87% of youth in custody have a psychological disorder and 8% to 20% had an intellectual disability.

Mental illness and cognitive impairment among the prison population is so high it should be assumed as the norm, rather than the exception.

NSW Mental Health Commission said large scale investment in effective prisoner diversion programs along with mental health and disability services are needed. (3)

(1) Mental Health Council of Australia Media Release 2010

(2) Health of Australia's Prisons. Australian Institute of Health and Welfare 2015

(3) Michaela Whitbourn, Mental Illness and Cognitive Disability 'The Norm "Among Prisoners. Sydney Morning Herald August 10th 2017.

WEEK 9: MINISTERING TO PEOPLE WITH MENTAL ILLNESS AND THEIR FAMILIES

The dignity of the individual is paramount in our belief that we are all created in the image and likeness of God.

Our language should reflect that belief. When talking about mental illness, we need to use “people first language”.

We refer to people as the persons; they are not the disease they have. It is better if we say “a man or a woman with a mental illness”.

We avoid referring to people using terms like “the mentally ill”. As people of compassion and justice we should never use stigmatising language or demeaning terms.

Careful use of language is more than being “politically correct”. It is a way of communicating that people with mental illness, as Pope St John Paul II said. “Have the inalienable right not only to be considered as an image of God and therefore as a person, but also to be treated as such”.

People with mental illness and their families often feel isolated from their parish and thus isolated from God. Isolation is often caused by the stigma of the disease, or fear of being judged inadequate or weak willed.

There can be the misperception that God is punishing them for something they did wrong.

We can support people with mental illness and their families with unconditional non-judgmental love in the following ways:

We can increase our awareness of mental illness and where to seek help.

We can offer prayers and support to individuals and families who are affected by mental illness.

We can serve on parish committees for outreach to individuals and families, be involved in peer to peer support and work on justice issues affecting mental health care.

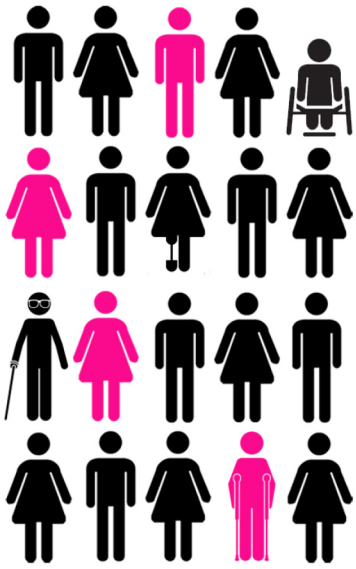
WEEK 10: MENTAL HEALTH AND PASTORAL CARE

At this point the specific goals for the parish can be outlined. Some suggested beginnings are:

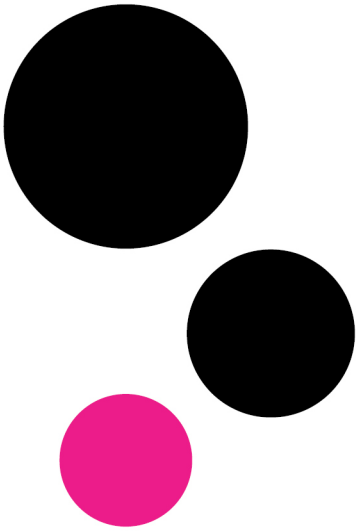
- Plan an educational evening with a speaker, video or panel discussion regarding issues facing people with a mental illness and their families
- Have groups or organisations in the parish meet to discuss further steps to be taken
- Invite a group of parish leaders to develop this ministry.
- Set up a 'Do Not Be Afraid' ministry
- Set up a social justice group and focus on advocacy for people living with mental illness

The Need

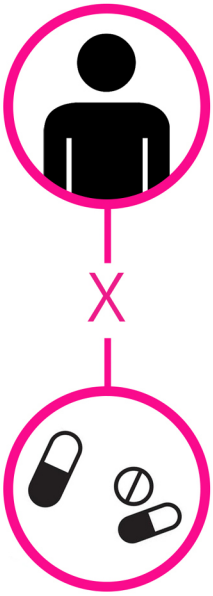
In our parishes and communities:



In each year, **1 in 5 Australians** will experience a mental illness



Mental illnesses are the **third leading cause of disability** in Australia



Only 54% of people with a diagnosable mental disorder receive mental health service

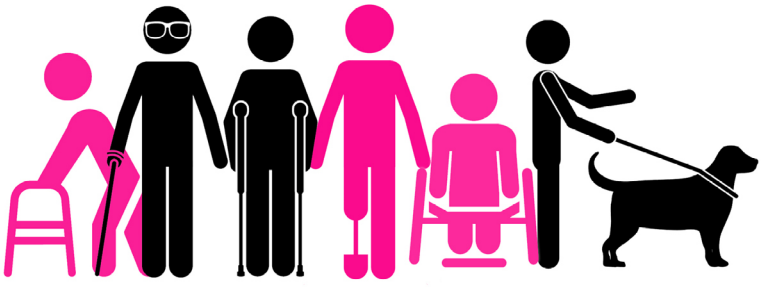
IN THE YEAR 2017

Death by suicide was the leading cause of death for young people aged 5-17

3,128 people in Australia died from intentional self-harm (2,358 males and 780 females).

A high percentage of these people had a diagnosable mental disorder

Almost half (48%) of people with severe or profound disability had mental health problems, compared to 6% of people without disability.



People who experience major mental illnesses such as schizophrenia, bi-polar disorder, major depression, obsessive compulsive disorder,anxiety disorders, personality disorders and others tend to be isolated and marginalised by society.

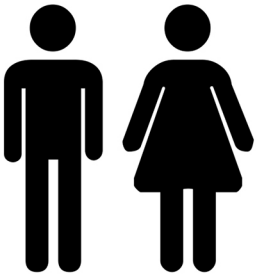
(1) Australian Bureau of Statistics (2009). *National Survey of Mental Health and Wellbeing. Summary of Results* 4326.0 2007 ABS Canberra
(2) Ivancic,L., Perrens, B., Fildes, J., Perry, Y and Christensen, H., *Youth Mental Health Report 2014.* Mission Australia and Black Dog Institute, Sydney.
(3) Australian Institute of Health and Welfare (2012) *Perinatal depression; data from the 2010 Australian National Infant Feeding Survey* AIHW Canberra
(4) Australian Institute of Health and Welfare . *Australia's Health* (2014) AIHW Canberra

On homelessness

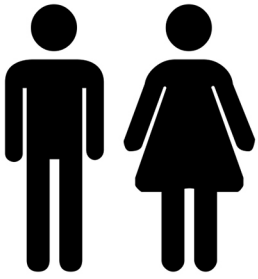
Since the 1960s, the "deinstitutionalisation" of mental hospitals sought to put mental healthcare back into the community. Over the nearly 60 years since, it is well documented that the lack of a commitment and funding to community mental healthcare has created a crisis for those who experience mental illness. Poverty affects many of them. Even those on the Disability Support Pension find few rental properties affordable, while those on Newstart Allowance find it is almost impossible to pay for shelter, food and other essentials.

Mental illness is one factor that contributes to the level of homelessness in Australia, with 27% of people who accessed specialist homelessness services in 2016-17 having a current mental health issue.

75% of people who were on the streets or in homeless shelters had mental illness.



28% of men **48%** of women
HAVE DEPRESSION



23% of men **44%** of women
HAVE SCHIZOPHRENIA

33% have a **major mood disorder**

26% live with an **anxiety disorder**

93% of homeless in inner Sydney have experienced trauma

58% of all homeless people had been **seriously physically attacked or assaulted**

55% had **witnessed someone being badly injured** or killed

68% of women had been **sexually assaulted**

Australian Bureau of Statistics (ABS) Catalogue 3303.0 Cause of Death Australia, 2017 released in September 2018
(25) Michaela Whitbourn, *Mental Illness and Cognitive Disability 'The Norm " Among Prisoners.* Sydney Morning Herald August 10th 2017.

Suicide

is a prominent public health concern in Australia.

In 2017, 

people in Australia died by suicide.

This is eight people a day. It is more than the number of people who die in motor vehicle accidents or because of skin cancer in a year.

Suicide is the leading cause of death for Australians between 15 and 44.

The **highest suicide rate** (suicide deaths per 100,000 people) by

GROUPS AT INCREASED RISK OF SUICIDE

- Men (around three times more likely than women, although more females attempt suicide)
- Aboriginal and Torres Strait Islander people (double that of non-Indigenous Australian)
- People who have previously attempted suicide
- People bereaved by suicide
- Members of the LGBTQI community
- People who live in rural and remote areas
- people from culturally and linguistically diverse communities
- Mental disorders such as major depression, psychotic illnesses and eating disorders especially after discharge from hospital or when treatment has been reduced.
- People with alcohol or drug abuse problems

WHY?

There is no single reason why people take their lives. It can be a combination of causes including social and emotional distress, trauma, social isolation and mental and/or physical illness.

Australian Bureau of Statistics (ABS) Catalogue 3303.0 Cause of Death Australia, 2017 released in September 2018
Mindframe Media

Mental illness in Aboriginal and Torres Strait Islander people

DEPRESSION

Generally, **among Aboriginal and Torres Strait Islander men, severe mood disorders are about 1.2 times that rate of the general population**, while among women it is the same as the general rate.

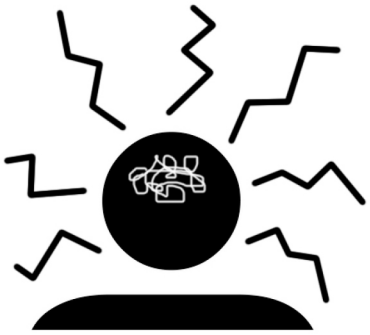
A survey of Aboriginal people attending a community health service in Victoria showed that **54% were suffering from psychiatric illness and that depression was the most common form**.

Another community survey showed **high levels of anxiety and depression, with a rate of 50% being three times higher than for other Australians.**

ANXIETY

Community surveys show **rates of anxiety of 1.5% on Mornington Island, 1% in the Kimberley and 5% in Bourke**. The Western Australian Child Health Survey showed that **up to one quarter of surveyed children aged 4-17 may be at risk of developing behavioural disorders associated with anxiety conditions**

PSYCHOSIS



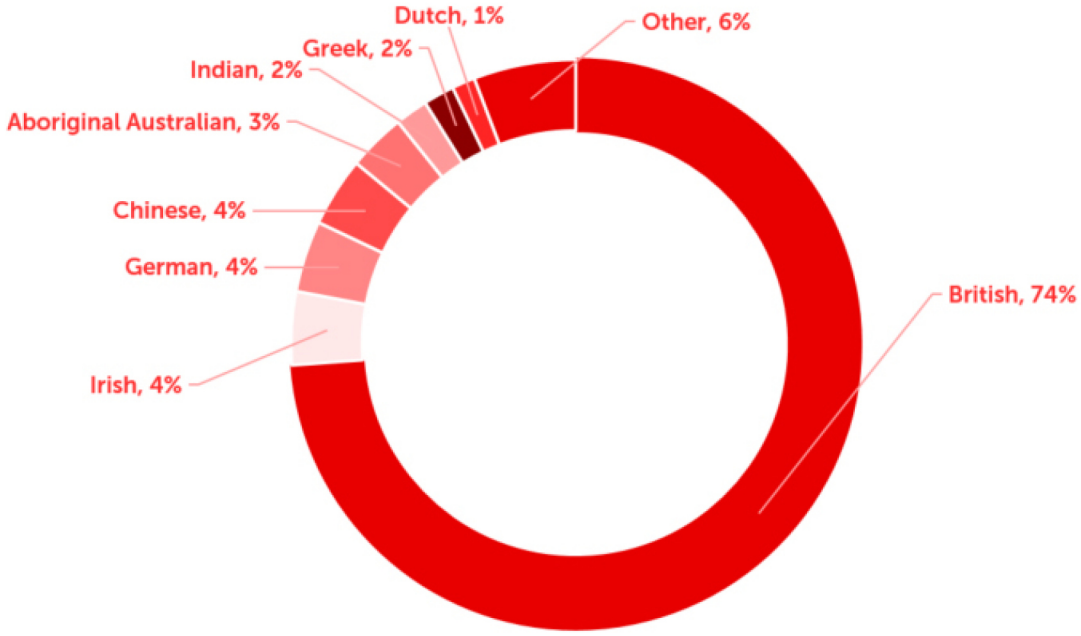
Tribal people in central Australia have a rate of schizophrenia of 0.4%. This contrasts with the high rate of psychosis currently affecting this population. However, psychosis in the context of substance abuse is a significant issue for the Aboriginal and Torres Strait Islander population at present.

Aboriginal and Torres Strait islander men are admitted to hospital with mental disorders due to psychoactive substance misuse up to 4.5% higher than the general Australian population. Among women it was 3.3%.

(5) Parker, R., and Milroy, H., *Mental Illness in Aboriginal and Torres Strait Islander People,* Working Together 2010 telethonkids.org.au Chapter 7.
(6) Pink, B, Allbon, P, *The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples 2008*. Canberra. Australian Bureau of Statistics
(7) Hunter, E. Mental Health in Thompson, N editor: *The Health of Indigenous Australians*. Melbourne. Oxford University Press 2003.
(8) McKendrick,j, Cutterm, T, Mac Kenzie, A., Chiu, E, *The pattern of psychiatric morbidity in a Victorian urban Aboriginal general practice population*. The Australian and New Zealand Journal of Psychiatry. 1992: 26; 40-7
(9) Jorm, A, Bouchier, SJ, Cvetkovski S, Stewart, G, *Mental Health of Indigenous Australians; a review of findings from community surveys*. Medical Journal of Australia 2012: 196: 118-121
(10) Zubrick,SR, Silburn, SR, Lawrence DM, Motrou, FG, Dalby, RB, Blair RB et al, *The West Australian Aboriginal Child Health Survey*. Curtin University of Technology and Telethon Institute for Child Health Research 2005
(11) Kidson,M, Jones,I, *Psychiatric Disorders among Aborigines of the Australian Western Desert*. Archives of general psychiatry. 1968: 19: 413-17

Mental illness among people from culturally and liguistically diverse backgrounds

Over 200 languages are spoken in Australia. The principal ethnic backgrounds of Australia's population are:



People from culturally and linguistic diverse (CALD) backgrounds are less likely to access mental health services. This is related to **difficulties in understanding and accessing general systems of care** and lack of services that are culturally safe and appropriate.

Stigma, lack of information about mental illness health services, lack of services that are appropriate and accessible, poor communication and cultural differences between clients and clinicians prevent early intervention and ongoing partnerships with service providers. This can result in people from CALD groups being over-represented among involuntary admissions to psychiatric hospitals and in jails.

Stigma had a particularly strong impact in some cultures. The importance of privacy is stronger in some cultural groups than others.

In many transcultural contexts it is the family, rather than the individual, that must be the focus of interventions to encourage awareness of mental health and access to the range of supports that may be needed.

The role of the GP is critical for this group. Specific skills are needed by them, such as the ability to work with interpreters and being aware of verbal and non-verbal communication differences.

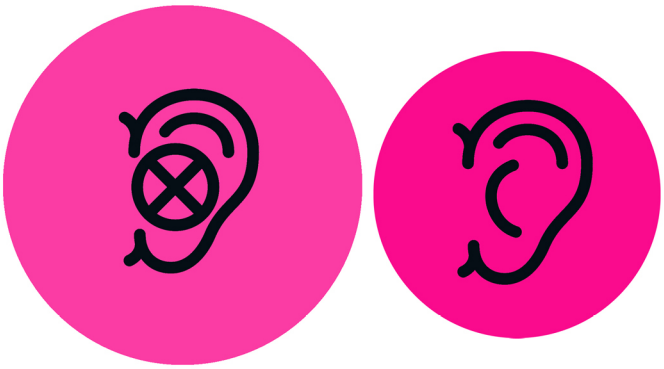
(12) World Atlas.com
(13) Mc Donald & Steel 1997 *Pathways to Recovery: Preventing Further episodes of Mental Illness* , Dept of Health , Australia
(14) *People From Culturally and Linguistically Diverse Backgrounds, Pathways of Recovery : Preventing Further Episodes of Mental Illness* . Dept of Health 2006. Internet Publications .

The Deaf Community and Mental Illness

It is estimated that **more than 800 000 Australian Deaf and hard of hearing people experience mental illness** some time in their life.

People who are Deaf or hard of hearing are at increased risk of mental illness due to

- Isolation due to differences in language
- Trend towards mainstreaming in schools
- Reluctance of some medical professionals to engage
- Struggles to find appropriately trained Auslan interpreters for mental health appointments
- Mental health professionals lacking knowledge of the communication needs of the Deaf and hard of hearing community
- Lack of accessible materials and programs for the Deaf and hard of hearing community on mental health and wellbeing, leading to incorrect diagnosis and treatment



At a minimum, Deaf people experience a prevalence of mental illness equal to that of the hearing population, with some evidence suggesting **children with hearing loss are one and a half to two times more vulnerable to mental health problems** compared to hearing children.

Consensus Statement on Mental Health and Deafness. See it Through Deaf Eyes: Healthy Deaf Minds. Deaf Children Australia 2010.

Mental illness and prison

Mental illness and cognitive impairment among the prison population is so high it should be assumed as the norm, rather than the exception.

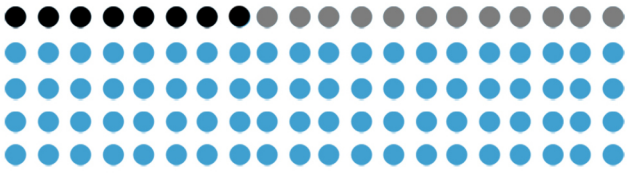
Up to 80% of inmates in Australian prisons have a mental illness

Magistrates in regional areas are sending people with a mental illness to jail as **there is often no treatment or mental health facility available**

49% all people entering prison had been told by a health professional that they had a mental health disorder and **27%** were on medication

1 in 4 receive medication for mental illness while in prison

87% of youth in custody have a psychological disorder.



8% to 20% had an intellectual disability

(23) *Mental Health Council of Australia Media Release* 2010
(24) *Health of Australia's Prisons* . Australian Institute of Health and Welfare 2015
(25) Michaela Whitbourn, *Mental Illness and Cognitive Disability 'The Norm " Among Prisoners.* Sydney Morning Herald August 10th 2017.

Stigma and mental illness

Due to the associated stigma, **people are unlikely to tell anyone at work or in the neighbourhood that they have a major mental illness.** Another group are able to work but sometimes find their illness debilitating and have to take time off. Others may never be able to work or can do so only in supported employment.

The good news is that, for many people, mental illness is treatable and manageable.

70-90% of people receiving the best combination of psychiatric care, medication, community and spiritual support have significant reduction in symptoms and improved quality of life.

Unfortunately, **people are often reluctant to seek help or treatment because of the stigma society puts on mental illness.** Even if people do seek help, they often run into the limitations of an **inadequately funded and poorly targeted mental health system.**

‘Do not be Afraid’ Ministry

HOW DO WE START?

People living with mental illness are present in all parishes. Some people will share their experiences and be open about their experiences and ask for support. Some people choose not to share their experiences about living with mental illness and ‘suffer in silence’. As parishes we need to acknowledge that people with mental health challenges and their families are present in our communities.

Talking to parish leadership about mental health and wellbeing and starting a conversation about a ministry to welcome and include all people might be the first step.

Parish leadership may consider asking the question: ***Are we a welcoming and inclusive parish community?***

One of the key concepts when welcoming and including people to a parish community is to become a ‘listening’ community. Sessions in active and reflective listening might be a good place to launch the ministry.

As a parish, we are called to welcome, accept, support and include all people in our commitment to our baptismal promises. To achieve this parishes can consider the following:

- **Education:** educating people about what mental illness is to destigmatise it. This can be achieved through bulletin articles, preaching, and training ushers and greeters. All of this welcomes people into the church and opens a parish up for having conversations.
- **Acceptance:** accepting people for who they are. Many times we only want to accept people as we want them to be, not for who they really are. We need to understand that there are people who have limitations and to welcome them. If people are on medication, for example, sometimes it can affect their energy or their abilities.
- **Accompaniment:** Parishioners do not have to be psychiatrists, but we all have a spiritual calling to stand with people. We can ‘stand’ with one another by:
    - Visiting the person at home, in the hospital or hostel
    - Finding out about specific services in your community
    - Advocating for the person on a local or national level.

HOW TO RUN A WORKSHOP

The workshop template is designed as a guide to running a workshop to establish a mental health ministry.

The workshop template can be adapted for diocesan, deanery, parish and ecumenical settings.

The format and materials can be adapted according to parish cultural practices and location.

The workshop can be spread over two days, a weekend or as a series of evenings.

Tips for holding a workshop

- Form a committee to be responsible for the workshop
- Decide on the date and time of workshop
- Decide on delegation of jobs
- Agree on agenda/running sheet
- Invite people to volunteer for the workshop and provide training in active or holy listening
- Invite guest speakers
- Collect relevant material for handouts
- Organise videos and other visual resources if required

- Book the room and ensure it is accessible for participants' requirements
- Send out invitations, advertise in parish bulletin and schools. Ensure the invitation is accessible and available in different formats.
- Organise the evaluation sheet
- Organise refreshments
- Discuss any changes to the program with organising team.

Example of Package/Handouts

- Fact sheet
- Prayer sheet for opening prayer
- Brochures of local mental health services
- Other appropriate brochures – e.g.: Advocacy types and tips
- Evaluation sheet

LAUNCHING AND SUSTAINING THE MINISTRY

The responses from the evaluation sheets will assist in deciding what the ministry will look like, how it will run and the main goals for outreach. It is important that the evaluation sheet is designed to highlight commitment, education and formation, volunteers and the general 'feel' of participants to commit to the ministry.

The planning committee might consider producing a short report for clergy, the pastoral council and parishioners to assist with the decision and commitment to establish a ministry.

The report will need to state the

- Purpose and goals of the ministry
- Prayer to support the ministry
- Training and formation for volunteers and leadership
- Regular meetings and debriefing times for participants and volunteers
- Strategies around personal, local and national advocacy
- Regular evaluation of ministry
- Networking with local services and advocacy groups

Once the decision has been made to go ahead, spend time in prayer to discern the way forward and leadership. Make prayer a central part of the ministry.

EVERYDAY EXPERIENCES

One big mental barrier is tiredness. It can sometimes be very hard to overcome. Mental instability and unpredictability is also hard to deal with as well as the often distressingly severe side-effects of medication used to treat mental illness. An attitudinal barrier is the stigma attached to mental illness. Many people are afraid of [people with mental illness]. They think lots of things: (1) schizophrenia = Dr. Jekyll and Mr. Hyde! Nothing could be further from the truth! Schizophrenia is a distortion of reality and [people with mental illness] are rarely violent. (2) That because mental illness can't be readily seen, it can't be readily treated and so should be feared! This is generally simply not true! These days, there are much safer and more medications available and much more is known about mental illness! Talking about your mental illness to a psychiatrist brings it out into the open and so makes it much more easily treatable!

WORKSHOP TEMPLATE

SAMPLE WORKSHOP ON MENTAL ILLNESS AND PARISH COMMUNITY OUTREACH

Preparation:

- Invite guest speakers
- Prepare agenda
- Agree on the contents of the package. e.g.: brochures of local services, fridge magnets with mental health emergency numbers, prayers, St Vincent de Paul, information about the parish, deanery, diocese.
- Prepare packs before meeting
- Check accessibility of venue
- Check any dietary restrictions
- Prepare a 'quiet space' in the venue with a trained volunteer. This space will support participants who may experience strong feelings as a result of workshop topics. The space could include access to music, art and/or reading.

Each participant receives a packet of information about mental illness.

8.45 am - Arrival –Registration

9.00 am - Opening prayer

9.15 am - Welcome and Introduction

- Introduction of speakers and agenda
- Attendees give a brief introduction of themselves.
- Go over handouts. It is important that attendees understand and know what is in their packets.

9.25 am - Group processing.

- Personal experience with a person with mental illness.
- Separate into groups of four and share an experience you have had of a person with mental illness. The person may have been a relative, friend someone at work or on the street. No one should be made to share if he or she is not comfortable, but everyone should be given the opportunity to share.

9.50 am - Video on mental illness in Australia. (See Video Links)

- Information about mental illness and its effects on the individual and the family.

10.30 am - Break

10.45 am - Input from a person who is living with a mental illness.

12.00 nn - Lunch

12.30 pm - Speaker;

- Psychiatrist or mental health worker. This section provides professional information about mental illness and a Question and Answer opportunity.

1.45 pm - Video such as "Welcomed and Valued".

- The importance of the parish community involvement and contribution

2.15 pm - Tea/coffee break

2.30 pm - Speaker.

- Parish community opportunities/ models for ministry. Examples of successful ways faith communities have welcomed people with mental illness and their families.

3.00 pm - Wrap-up.

- Questions.
- Evaluation.

LITURGIES, PRAYERS AND RESOURCES

The following section provides example of liturgies, prayers and resources.

Prayers can be printed as an insert in the parish bulletin or produced on small cards to:

- Celebrate and acknowledge World Mental Health Day
- Launch a mental health or welcome ministry
- Include in a Liturgy for Healing of the Sick.
- Provide support to an individual
- Used with visitations

Each Day

Written by Rita Sebastian Lambert

A spiritual exercise for persons with mental illness to be said EACH DAY.

How to use Each Day: This prayer was used as part of a workshop for people living with mental illness. The workshop was designed to listen to and share stories with people living with mental illness.

Parishes could focus a whole or part retreat day around this prayer to promote improved mental health and wellbeing.

The prayer could be used with Anointing of the Sick liturgy.

Invite parishioners to practice this prayer to improve their mental health and wellbeing.

I will recall that I am a child of God.

I am one who is created out of Love.

I am chosen, good, holy and have purpose…a task to perform here on earth before I return to the Father.

I deserve to be treated as a person who has value and dignity.

I will embrace my illness or my family member's illness as a friend this day looking for what it is teaching me about the mystery of God and life.

I will not allow the stigma of mental illness to defeat me this day. I will choose to have power over stigma by detaching myself from the stigma.

I will talk to someone today who will encourage me to see my goodness and holiness as a child of God. Maybe we will share a prayer together for one another.

I will look for humour and reasons to laugh and be happy. Quiet joy will be my goal.

I will read a passage from Scripture or something from a book of devotion, inspiration or spiritual reading that will encourage me to trust and hope in the power and love of God.

I will seek twenty minutes of solitude, silence, prayer this day. If my mind won't quiet down, if my thoughts keep racing, I will offer that as my prayer to God. If necessary and helpful, I will listen to soothing instrumental music or inspirational/ religious music to quiet me and remind me that God is present.

I will walk outdoors marvelling at a sunrise, a sunset, the song of a bird, the soothing colours of nature, the serenity of green grass, a blue sky, the softness of the pastel coloured blossoms and the peaceful waters of a river, lake or creek that ripple

and flow. I will remind myself that everything in nature is a reflection of the Creator and pleases the Creator just as it is and so do I just as I am.

I will delight in the knowledge that we are each created different because it is in our differences we make a more powerful and beautiful whole. We reflect a different aspect of the mystery of Life and God. Individually and together we are a Masterpiece.

In God is my hope and my joy. I will give honour, glory and praise to God knowing and trusting what God has in store for me. We do not seek or like suffering but our suffering can make us strong in many ways and more compassionate and loving to others; our brothers and sisters in the Lord.

Knowing for sure that although I long for God, God's longing for me is even greater.

I will rest in that knowledge this day!

Prayers of the Faithful

Choose Prayers of the Faithful that suit your community and the liturgy.

PRIEST CELEBRANT'S INTRODUCTION

Let us pray that our Heavenly Father will bring health of mind, body and spirit to his beloved sons and daughters.

READER/S

1. For all those who face discrimination and stigma due to mental illness, that they will find welcome and inclusion as branches of Jesus' vine.

   Let us pray to the Lord.

   R. Lord, hear our prayer.

2. For all men, women, and children, and on this special day especially mothers, who themselves or within their families deal with mental and emotional crises: that the joy and love of Jesus may bring them comfort.

   Let us pray to the Lord.

   R. Lord, hear our prayer.

3. For all those who struggle with mental health problems: that the Church and public agencies will act with justice to ensure the availability of necessary supportive services to aid in their recovery

   Let us pray to the Lord.

   R. Lord, hear our prayer.

4. For all Christians and people of good will: that the Holy Spirit will inspire them to open their hearts and arms to welcome those who face mental illness,

   Let us pray to the Lord.

   R. Lord, hear our prayer.

5. For all who provide services for people whose lives are affected by mental illness, especially social workers, counsellors, mental health professionals and pastoral caregivers: that they will bear witness to God's spirit of love.

   Let us pray to the Lord.

   R. Lord, hear our prayer.

6. For all persons with a mental illness, and their families: that they will find effective treatment for the illness and understanding and acceptance from others,

   We pray to the Lord.

   R. Lord, hear our prayer.

7. For people who live on the streets without homes or hope: that they will find sanctuary, security and loving support.

   We pray to the Lord.

   R. Lord, hear our prayer.

8. For people with mental illness who are confined in jails and prisons: that they will be supported in their desire for a good health, a renewed heart and freedom.

   We pray to the Lord.

   R. Lord, hear our prayer.

9. For all mental health professionals and those that provide support services: that they will be blessed with compassionate hearts and minds towards those that they serve.

   We pray to the Lord.

   R. Lord, hear our prayer.

10. For our elected government officials: that they will prioritise the financial needs of our society's most vulnerable people, particularly those in need of mental health care.

    We pray to the Lord.

    R. Lord, hear our prayer.

11. For all who suffer from mental illness: that the darkness of stigma, labels, exclusion and marginalization they endure might be dispelled by the light of greater understanding, acceptance and respect for their human dignity.

    We pray to the Lord.

    R. Lord, hear our prayer.

12. For our Federal, State and Territory Governments: that they will be generous in their provision of targeted funding for mental health

    We pray to the Lord.

    R. Lord, hear our prayer.

13. For families who live with a loved one living with mental illness: that the Holy Spirit will help them understand and care for their parent or child effected by mental illness.

    We pray to the Lord.

    R. Lord, hear our prayer.

14. For all mental health care professionals: that they will experience support and gratitude from all people of good will as they seek new discoveries in brain research.

    We pray to the Lord.

    R. Lord, hear our prayer.

15. For each of us here present: that we will have the courage to reach out and form a caring community as we support those with a mental illness.

    We pray to the Lord.

    R. Lord, hear our prayer.

PRIEST CELEBRANT'S CONCLUSION

Gracious and loving God, you are the source of every blessing. We place our petitions before you through Your healing Saviour, Jesus Christ, who bore our illnesses and endured our sufferings, leading us to glory as our risen Lord, who lives and reigns with you for ever and ever.

ALL: Amen.

PRAYERS

Use these prayers for opening meetings, encouraging people to join ministries within the parish or any time we need to be reminded about the importance of welcome and inclusion.

One Body in Christ © Australian Catholic Bishops Conference 2009

Jesus, you invite and welcome all to you.

We praise and thank you for inviting and welcoming us to be one with you.

Gently remind and encourage us that we are called to announce the Good News that you teach us; that we are all made in God's image and we all have unique gifts.

Inspire us to actively invite and welcome all; for when we include everybody in the Body of Christ, we will then be truly one.

Send us your Spirit so that we, the Church, can strive to be a people of compassion and relationship, and a sacred place where our gifts are acknowledged, received and celebrated; for then we can truly proclaim that we are 'one Body in Christ'.

Amen

Living our Gifts © Australian Catholic Bishops Conference 2004

Loving God, author of all gifts;

We praise and thank you for all the gifts you have entrusted to us.

Pour out your Spirit upon us so that, true to our baptismal promises, we may form faith communities that recognise and promote the gifts in all people so that we may all share in the mission of Jesus.

Inspire us to be a Church that is welcoming and accepting, and which sees everyone as an expression of Christ.

May our faith communities nurture and commission all members to live our particular gifts as a reflection and imitation of Jesus' life.

Give us the courage to be the light of welcome in the darkness of exclusion, a voice of gentleness in the wilderness of the unheard and an outstretched hand of love to those longing for community. Amen.

Healing Wounds (Jonathon Blundell - Used with permission).

Blessed are those who don't have it all together

Blessed are those who have run out of strength, ideas, will power, resolve or energy.

Blessed are those who ache because of how severely out of whack the world is.

Blessed are those who on a regular basis have a dark day in which despair seems to be a step behind them wherever they go.

Blessed are you, for God is with you,

God is on your side, God meets you in that place

LITURGY AND PRAYER LINKS

You might like to explore other resources for prayers at these links

- A prayer for those living with mental illness: https://www.aifc.com.au/prayer-living-mental-illness/
- The Uniting Church in Australia; Queensland SynodL iturgy: Mental Health Day of Prayer, by Pastor Beatriz Skippen 2016: https://ucaqld.com.au/wp-content/uploads/2017/01/MH_Day-of-prayer_liturgy2016.pdf
- Called to Care Liturgy: Mental Health Day of Prayer, Bracken Ridge Catholic Parish: https://ucaqld.com.au/wp-content/uploads/2017/01/MH_Day-of-prayer_liturgy2.pdf
- A Nouwen Network prayer page: http://nouwen-network.com/prayers.html
- Prayers for Mental Health: https://www.mentalhealthmatters-cofe.org/upload/prayers%20on%20a%20mental%20health%20theme.pdf
- A Prayer for Mental Health (STACEY GLEDDIESMITH: https://thinkingworship.com/2013/04/30/a-prayer-for-mental-health/

- **More resources can be found at...**
- A Nouwen Network: http://nouwen-network.com/index.html

STORIES

Following prompting from family and friends, Mark, 29, a successful accountant self referred to a counsellor at a local Centacare due to a 12 month history of increased drinking, excessive worry, loss of interest in life and physical symptoms of restlessness and insomnia. He had also withdrawn from most of his social activities and sport including local rugby union. Mark's popular younger brother had suicided 2 years earlier following a relationship breakup. This was a catastrophic event for the entire family and was sadly followed by the premature death of their father from a stroke 6 months earlier. Mark admitted to a broken relationship of his own, and 'vague' suicidal thoughts, but said he would never do that to his family. The counsellor decided that Mark needed to see a GP for anti depressant medication and required ongoing counselling for his unresolved grief and binge drinking. After 12 months of treatment Mark's symptoms were gone or much improved, he was in a new stable relationship, back playing football and his career was going well.

Disability Projects Office

Secretariat for Social Justice – Mission and Service

Australian Catholic Bishops Conference

GPO Box 368 CANBERRA ACT 2601

E: disability@catholic.org.au

T: 02 6201 9868

F: 02 6247 6083