

Welcome me as I am

Facilitators Resource Manual

This is section 3 of a 6-part manual on how churches can provide a respectful welcome in church to people experiencing mental health challenges. It was brought together by Ben Bano. The full structure is:

1. 'Something deep inside me' – exploring Spirituality and Mental Health. Written by Peter Gilbert
2. 'The healthy parish' – exploring protective factors in Mental Health at a time of uncertainty and recession.
3. 'Accept and welcome me as I am' – the ministry of welcome and inclusion. Addressing stigma and discrimination in mental health through understanding the overall context of inclusion. Written by Peter Bates and Hilary Elbourne
4. 'The ministry of hope' – the recovery model in Mental Health and its implications for our parish and deanery community.
5. 'Where is God in my hour of need?' - spiritual and pastoral support for people with mental health needs in our parish and deanery community.
6. Understanding mental health needs and getting help for service users and carers – signposting to effective services.

Section Three – Accept and welcome me as I am

By Peter Bates and Hilary Elbourne

God be in my head and in my impairments.

God be in my eyes and in my blindness.

God be in my ears and in my deafness.

God be in my head and in my madness.

God be in my legs and in my lameness.

God be in my hands and in my clumsiness.

God be in my mouth and in my silence.

God be at my end and in my dementing.”

(Janet Lees, speech therapist, revisits the Sarum prayer. Printed in the Religion and Spirituality Division Quarterly, Spring 2006, page 3)

Mental distress and illness is normal

Taking the whole of life together, it is unusual to have an able body, an agile mind and a buoyant spirit. We all start our lives needing others to keep us clean, fed and warm, many of us end our lives that way, and much of the time in between is characterised by aches and pains, disabilities and impairments, worries and troubles. This is not about being gloomy, but simply recognising that the times when we are bursting with health, bronzed, athletic, and overflowing with joy are temporary, abnormal phases for most of us.

Mental distress is a normal part of human experience, and one in four people experience treatable mental illness at some time of their lives, so any congregation with more than three people is statistically likely to have some members with personal experience of distress. We all live our lives with a mix of illness and wellness, and some people who struggle with obsessions, or troubling ideas or feelings demonstrate kindness, generosity, forgiveness and hope, while others have no sign of any formal mental illness but remain trapped in bitterness, guilt and self-centredness.

Jesus supports inclusion

Jesus spoke to a society that excluded all kinds of people – prostitutes, foreigners, tax collectors, criminals, lepers, and those we would, these days, call mentally ill. These divisions split ‘us’ and ‘them’ and dehumanise the people that God had made. Over the centuries, we have seen these divisions played out again and again, in concentration camps, apartheid and ethnic cleansing, homophobia and disability hate crime, and even the school playground.

By his words and his actions, Jesus opposed such divisions and today stands with all who welcome those who are different from themselves. He stands with all those who accept the people that others would call outcasts.

People with mental health issues have long been excluded. In the eighteenth century, people would visit London zoo to look at the animals and then travel on to Bethlem psychiatric hospital to look at the inmates. The Victorians built many asylums and surrounded them with high walls to protect patients from the abuse and taunts of the general public. In the twentieth century, hostels, sheltered workshops, day centres and social groups were created to complete the segregation of people experiencing mental health problems from the rest of the community. In their heyday, psychiatric hospitals had shops, newsagents, churches, banks, libraries, gardens and concert halls inside the walls. As a result, the rest of society lived as if mental illness did not exist and people become ashamed and secretive about their own problems.

In our own century, efforts have begun to combat this history of exclusion. The simple message from successive governments is that people need high quality help *in situ*, so that, as far as possible, they do not have to give up their usual life. People

might need some time off from the job, but should not have to give up work altogether, they might need a short period of time in hospital, but they should not lose their home, and they might want the support of people who have travelled the same road, but they should not lose all their friends. This is known as *social inclusion*.

Are mentally ill people dangerous?

For some members of the public, including people with mental health issues is a frightening prospect. Horror films, sensationalist journalism and an increasingly safety-conscious society have linked mental illness with violence. Occasional tragedies, in which people maim, murder and abuse others are incomprehensible to most people, and the common explanation is that the perpetrator must be 'mad' to do such a thing. Sadly, these events sometimes occur because of depression or delusions, but they remain rare. Meanwhile, around one in four of us will have some mental health problems at some stage in our life.

Over the last 500 years, the world has become a much safer place, and we are around 50 times less likely to be murdered for any reason at all than we would have been in the Middle Ages. In the last 50 years, murders have increased somewhat, but there has been absolutely no change in the murder rate that can be attributed to mental illness. For every mental illness related death, there are 70 deaths on the roads. Whilst nothing can be guaranteed for anyone, the vast majority of people with mental health difficulties are no danger at all to anyone else.

Three possible causes of exclusion

Many people with mental health issues remain excluded from ordinary life. They are more likely to be unemployed, homeless or in temporary accommodation, have other health problems, be out of education and missing from social groups and community activities. Along with many unemployed people, they are less likely to volunteer their time for charitable and community purposes. They may be less likely to get involved in church or to stay involved once they join.

There are three possible reasons for this exclusion:

- Issues to do with the person themselves and their mental health difficulties
- Issues to do with the community and its hostility towards people who are seen as different
- Issues to do with the support that is available from the welfare state – doctors, social workers, care staff, jobcentres and so on.

Most real-life situations play out in all three fields. For example:

- a depressed worker might find it difficult to get out of bed and face the workplace on a particularly bad day, the community of fellow workers may pour scorn or suspicion on any of their number who are mentally ill, and the doctor may sign the person off sick without thinking about the impact on his future employment prospects.
- A member of the congregation who struggles to leave the house because of her anxiety may miss the mass for a few weeks, the congregation may not notice or do anything about it, and the psychiatric nurse may hint that faith is reinforcing her feelings of guilt and failure.

The Social Model of Disability

The remainder of this chapter will pursue the second of the three possible causes of exclusion that were set out above – the idea that the local community has a part to play in whether people join in, feel welcomed, contribute and maintain their engagement. Our part of the local community is the church, and so we will examine what the local congregation can do to welcome people with mental health issues.

It is based on a theory called the Social Model of Disability and this approach accepts people for who they are and looks for the physical and social environment to make adjustments so that they can fully participate. In the Social Model, a wheelchair user is not disabled until someone introduces staircases, and the focus is on putting in ramps, lifts and welcoming attitudes so that everyone can contribute as equals.

Few people with mental health difficulties need ramps and lifts, but we need to look for similar things that remove barriers and help people engage despite their mental health issues. For example, some psychiatric medications make people feel drowsy, and so offering a service later in the day and avoiding criticisms of worshippers who fall asleep will help people feel understood rather than judged. Many of the medications that people take dry up saliva in the mouth, so simply offering a water jug and some glasses will help people to feel welcomed and able to sit through the service.

Three kinds of provision

Over the past two hundred years, there have been three main responses to excluded people, whether this is disabled children, people with learning difficulties or those with mental health issues. They focus on special buildings, special groups or individual support. For mental health, the special buildings include psychiatric hospitals, residential care and nursing homes, day and drop-in centres and sheltered workshops. Groups include therapy and support groups, sometimes run as self help groups such as Depressives Anonymous or the Hearing Voices Network.

While separate buildings and groups provide an opportunity for people to meet in a supportive environment, they deprive the wider community of the contribution of this group of citizens and further isolate them from wider roles and relationships. People who spend a lot of time around mental health buildings and groups find themselves living in what might be termed a 'benevolent ghetto'.

The third approach is to support people to reconnect with the wider community or retain their connection to it, to establish friendships with people who have had different experiences, and to keep ordinary life going, despite their difficulties. This approach offers the best hope for building a community where everyone can belong.

Church history has examples of each of these three responses to exclusion – separate church buildings for sick people, Black people or poor people, separate groups for learning disabled people, such as a Faith and Light group or for those exploring the interplay between hallucinations and spiritual revelations, and individual support for people to join in with the mainstream. A local congregation may use a separate building for very good reasons (such as the chapel inside a prison), or a separate group (where people are sharing their personal experience of the 'dark night of the soul' and reflecting on the Psalms together), but, without a parallel agenda of making the wider church accessible to ex-prisoners or those facing depression, their work is a dead end rather than a through road.

This is at the heart of the mission of the church – welcoming everyone, irrespective of status, wealth, mental health or ethnicity. This chapter pursues the final option – how to support people to participate in the same things that everyone else does, rather than creating separate services, activities or groups. That way, the whole congregation is involved and everyone benefits.

Mere attendance or true belonging?

What does it mean to belong to a community? It means many different things, ranging from someone knowing your name to feeling part of a joint project and being able to contribute your gifts and abilities. In some ways, community is always just out of reach, a foretaste of heaven that we are constantly searching for, an aspiration rather than an achievement in this life.

If we are to include people in our church community we need to welcome them as they are and treasure their gifts, even when those gifts are awkward or hard to spot. Someone who speaks hesitantly teaches us to slow down, someone with unusual ideas teaches us to listen with our heart rather than our head, someone who can't sit still during the prayers teaches us to find the silence within ourselves.

Instead of making demands on the person to change, we are invited to change the way we do things and maybe our attitudes as well, so that there is a place for everyone. This means a place to belong, to contribute, to be valued for who we are, rather than just a place to physically attend from time to time.

Every organisation creates formal and informal rules or traditions that govern how people can participate. Sometimes these rules make sense, such as insisting that the treasurer be honest and good at maths! But in other places, the rules make less sense and form a barrier to many, including those experiencing mental distress.

For example, one church ran a luncheon club for older people. They welcomed people of any faith or none to eat lunch, but only church members could serve out and wash up. Elsewhere, in a church meeting, the chairperson passed a microphone around so that anyone who wanted to speak to the whole group could do so, but systematically prevented a certain person from having a turn. In a third place, nobody offered lifts to the church and so only car owners could attend, and in a fourth, it was almost impossible to take a break from any role.

The challenge for the church is to remove all unnecessary barriers so that people can easily increase their involvement or step down from responsibilities for a time – so that all may worship.

So what can we do?

1. Invite people who have lived with mental distress to speak about their experiences in order to get the issue into the open and see the person behind the label. Create an environment where mental distress is not a taboo subject, but rather an acceptable issue to talk about from the front of church, in the pews and in the pages of the parish newsletter.
2. Find out how to get help from local mental health services (more of this in chapter 6) and ensure that the people involved in pastoral and care work in your congregation know about it.
3. Locate buildings and groups that have been set up for people with mental illness in your parish and offer to help with the chaplaincy service.
4. Develop local resources, such as prayers to use in church services. You may wish to look at the following websites: www.Pathways2Promise.org, www.MentalHealthMinistries.net, www.congregationalresources.org/mentalhealth.asp , www.nami.org/namifaithnet
5. Consider how to reach out and maintain your connection with people whose participation levels fluctuate. This will be the case for some people with mental distress, but not all, and also true for many other groups, such as those with very small children or some long-term health issues. Are there enough home visits and opportunities for people to build friendships through the congregation? Do people sense your ongoing interest and care for them in the times that they are in hospital or during other times of absence?
6. Be sparing with 'good advice', as crowding the person with instructions can feel oppressive and make problems worse. Respect people's preferences, especially if they prefer to avoid eye contact, handshakes or hugs.

7. Review all your activities to detect and lower barriers to real contribution and belonging. Would I feel able to speak about my own distress? Would a diagnosis of mental illness shut me out from things? If I needed support to participate, would this be available?
8. Offer a break to relatives who cannot leave their loved one alone.
9. Get involved in World Mental Health Day that takes place each year on 10 October. Take the message to your employer and social or neighbourhood group outside the church. Write to media organisations to encourage them when they report a positive story concerning mental distress, and perhaps challenge sensationalist reporting.

Discussion Questions

1. Can you think of a moment when you have personally felt included or excluded by the attitudes, actions or arrangements of the church or elsewhere? If you feel able to do so, please tell the group about it. Pay attention to the feelings, rather than discussing the fairness of the events too much.

2. Make three columns on a flipchart sheet and list the local examples you know about of mental health buildings, groups and individual support for participation in church life. Then think about the upside and downside of each of these options. End with a row of ideas for moving forward. Here's an example, but it's best if the group fills out the table for themselves.

Buildings	Groups	Individual Support
Locally, there is the chapel at the psychiatric unit and Father Brown celebrates mass there for inpatients each Sunday.	We have a 'mental health and spirituality' discussion group meeting in the church hall on Monday evenings. We don't know if anyone from the congregation attends.	Several people who we think might have mental illness attend the mass from time to time, but only one person in our group knows their names, and they don't attend anything else.
The positive side is it offers a chance for people who are detained to worship.	The positive side is that group members get a chance to relate their faith to their experience in a sympathetic and understanding group.	The positive side of this is that people are attending the church and may continue to do so after they are discharged from the mental health service.
The negative side is that it can associate churchgoing with illness.	The negative side is that the rest of the congregation miss out on the insights developed in this group	The negative side of this is that we have not really found ways for these folk to belong.
Possible action includes church members volunteering with the chaplaincy	Possible action includes inviting members of the group to give a talk to the rest of the congregation	Possible action includes getting to know the people concerned and moving our focus from attendance to

		belonging.
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3. Choose one area in which lay members of the congregation can get involved and talk about who would be eligible and who would be quietly discouraged from getting involved.

- Consider whether it is reasonable to exclude someone who is mentally distressed from participation in this aspect of church life.
- What would it take for someone with a mental health issue to be able to contribute? Do you need to redesign the activities, change attitudes or provide support?
- If there is time, choose a second and even a third topic area. Who do group members feel should be allowed to help with Sunday School, visiting elderly people, playing a musical instrument, or sitting on a committee?
- Report your reflections to the parish council.