Module 3 – Welcome Me as I am

Guidelines for Facilitators

You will need:

- A flipchart and pens to capture the points made during the meeting.
- Sufficient copies of the discussion sheets and testimonies for members of the group.
- Paper for sub-groups to record their thoughts.

Aims of this module:

To understand how people with mental health problems can feel excluded from community life and participation in the parish.
To reflect on how our parish communities can become communities of welcome.

When arranging this session:

Ensure where possible that parish organisations such as the SVP are included in your publicity and invitations. Suggested length of this session: 90 minutes

Programme/Plan for this module:

Opening Prayer (5 minutes). You will find some suggestions in the Resource section of this toolkit.

Introductions and Ground Rules (10 minutes)

Discussion 1 – Mental Health and Exclusion. Distribute discussion sheets 1 and 2 to the group. Ask the group to consider the implications of social exclusion and the Church's social teaching for our parish life. (20 minutes). List the ideas on the flipchart.

Discussion 2 – Mere attendance or true belonging ? Distribute discussion sheet 3 to members of the group. When they have read through the sheet, ask participants to discuss the questions at the end of the sheet. (20 minutes). When you reconvene for feedback, draw two columns on the flipchart, one looking at positive experiences of inclusion, the other looking at negative experiences. (20 minutes)

Discussion 3 - Taking inclusion forward in our Parish and Deanery community. Ask the group to consider how we might address the issues raised in the discussion so far. List the feedback on the flipchart. Then distribute the sheet 'Taking inclusion forward' and compare the ideas of the group to those on the sheet. (15 to 25 minutes)

Closing Prayer

For those interested after the session, distribute 'Some issues for further reflection and discussion'

Discussion Sheet 1 - Mental Health and inclusion

Exclusion and People with Mental Health issues. 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 hospitals 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.

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.

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.*

Discussion Sheet 2: Catholic Social Teaching and mental illness

- **'**Those who are marginalised and whose rights are denied have privileged claims if society is to provide justice for all. This obligation is deeply rooted in Christian belief' (The Church in the Modern World, #69. Second Vatican Council)

- Whoever suffers from mental illness 'always' bears God's image and likeness in [themselves], as does every human being. In addition, [people with 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' (Message to Health Care workers, Pope John Paul II, 1997)

- Every Christian, according to [their] specific duty and responsibility, is called to make [their] contribution so that the dignity of these brothers and sisters may be recognized, respected and promoted. (Pope Benedict XVI, 2006)

- 'I therefore encourage the efforts of those who strive to ensure that all people with mental illness are given access to necessary forms of care and treatment… I commend pastoral workers and voluntary associations and organizations to support in practical ways and through concrete initiatives, those families who have people with mental illness dependent upon them. I hope that the culture of acceptance and sharing will grow and spread' Pope Benedict XVI, 2006)

Discussion Sheet 3 – 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 take part in the life of the parish community.

Some questions for discussion

Can you think of a moment when you, a family member or a friend 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.

Discussion Sheet 4 – Taking inclusion forward in our parish – some ideas

1. Can we 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 in a Deanery Pastoral Council, from the front of church, in the pews and in the pages of the parish newsletter.

2. Perhaps we can find out how to get help from local mental health services (more of this elsewhere in this toolkit) and ensure that the people involved in pastoral and care work in your parish and deanery community 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. Can we develop local resources, such as prayers to use in a healing liturgy (see the resources section) For additional ideas you may wish to look at the following websites: www.Pathways2Promise.org, www.MentalHealthMinistries.net, www.congregationalresources.org/mentalhealth.asp , www.nami.org/namifaithnet, www.dayofprayerfordementia.org.uk

5. Can we consider how to reach out and maintain our 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 our parish community ? Do people sense our 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, for example those with dementia. For more ideas look at the module 'Caring about Carers'.

9. You can focus on mental health issues on the 'Day for Life' which takes place each July. 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.

Some issues for further reflection and discussion

Stereotypes and mental illness

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 main, 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 were 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 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

Lets look at 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 needs.

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 experiencing mental distress 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, 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 may be 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. Perhaps the final option is the most significant – how to support people to participate in the same things that everyone else does, rather than just creating separate services, activities or groups. That way, the whole parish community is involved and everyone benefits.

Participation in Church Life – some questions for reflection

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 our priest celebrates Mass there 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 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.*