

Clergy Outreach and Professional Engagement (C.O.P.E.)

Glen Milstein, PhD

Department of Psychology

The City College of the City University of New York

gmilstein@ccny.cuny.edu

Adapted from the article:

Milstein, G., Manierre, A., Susman, V., & Bruce, M. L. (2008). Implementation of a Program to Improve the Continuity of Mental Health Care through Clergy Outreach and Professional Engagement (C.O.P.E.). *Professional Psychology: Research and Practice*, 39(2), 218-228.

© 2008 Glen Milstein, Ph.D.

There are more than 260,000 religious congregations in the United States (1). These congregations—and their clergy—are a de facto part of the continuity of mental health care in the United States (2-4). This handout describes the initial implementation of a prevention-science-based paradigm to improve the continuity of mental health care through reciprocal collaboration between clergy and mental health professionals. Materials to disseminate this clinical and prevention intervention are included.

We have found that clinicians and clergy perform distinct functions which, while they only occasionally overlap, are complementary (5). Clinicians provide professional treatment to relieve individuals of their pain and suffering, and move them from dysfunction to their highest level of functioning. They also intervene, when possible, to prevent the relapse of mental disorders. In most cases, assuming resources are available, the less clinicians see of those under their care, the more successful the clinicians are. With some serious and persistent mental illnesses, clinical relationships—though they will wax and wane—will last through the patients' lives (6, 7).

Clergy and religious communities provide a sense of context, support, and continuity before, during, and after treatment (4, 8). Indeed, the better a person is functioning, the more that person can participate in the life of the congregation (9, 10). Unlike clinicians, clergy expect and hope to see their congregants as often as possible through the course of their lives. Clergy may know multiple generations within a single family. They will officiate at ceremonial events, at times following the lives of some family members from birth, through school years, to marriage, and until death. Through their relationships with congregants, clergy acquire comprehensive information, which (with consent) they could share with clinicians. By collaborating with clinicians, the clergy's personal familiarity and experience can be invaluable to facilitating appropriate and continuous mental health care for their parishioners by "*contextualizing*" the patient's illness and life history (11, pp. 398-399).

- *How can we build effective collaborative relationships between clinicians and clergy?*
- *How then can reciprocal collaboration facilitate and sustain the continuity of mental health care provided to individuals with multiple levels of functioning?*
- *How also can collaboration facilitate and sustain healthy functioning for the majority of persons who are members of religious communities?*

We propose a "Religion Inclusive" model. Our *Religion Inclusive* model reflects Kelly and Strupp's (12) finding that, "*matching of patients with the therapists by religious orientation would involve not so much the therapists' personal religious convictions as their ability to understand and deal sensitively with their patients' specific religious values*" (p. 39).

The *Religion Inclusive* model has two steps:

1. Assess the role of religion in an individual's life.
2. Educate oneself about that religious tradition. With consent, this could include contact with the patient's own clergy.

We have found that an inclusive, respectful model of interaction can involve a wide array of clergy and clinicians who collaborate to improve and maintain the emotional well-being of persons in our mutual care.

Description of C.O.P.E.

Since 1998, we have developed a multidisciplinary, multi-faith, and research-focused, program of Clergy Outreach and Professional Engagement (C.O.P.E.). The C.O.P.E. program facilitates reciprocal collaboration between clinicians and community clergy, regardless of their religious traditions. We approach our interprofessional relationships using the resource collaborator model (13), which recommends that *“participants acknowledge their own and each other’s resources and limitations, share their resources, and recognize their reciprocal gains”* (p 388). We share a single outcome measure of successful collaboration: the emotional well-being of the persons in our mutual care.

Two central ideas guide the C.O.P.E. program:

1. Through professional collaboration clergy (with their discrete expert knowledge about religion) and clinicians (with their discrete expert knowledge about mental health care) can better help a broader array of persons with emotional difficulties and disorders than they can by working alone (14, 15).
2. In order to perpetuate collaboration, clergy and clinicians must find their work eased by C.O.P.E. One must design programs so that they result in **“Burden Reduction”** for each group.

We define **Burden Reduction** as: *a reduced need for one group of service providers to deliver direct care, as a result of sharing expertise with service providers from another group or profession.* The objective of C.O.P.E. is to improve the care of individuals by reducing the caregiving burdens of clergy and clinicians through consultation and collaboration.

C.O.P.E. and Prevention Science

We used the four prevention science categories from the National Institute of Mental Health (NIMH) (16-18) (Figure 1) to develop two handouts: one designed for mental health professionals (Figure 2), and the other for clergy (Figure 3). These handouts describe four stages of care; they illustrate when it would be appropriate for clergy to contact clinicians, and for clinicians to contact clergy.

Figure 1 provides the NIMH prevention category definitions under their headings. In this diagram, the comparative size of the areas of the rectangles illustrates the proportion of the population within a category targeted to receive prevention interventions. The level of shading shows the level of risk of impairment to the population receiving the intervention. Going down the four categories, the proportion of the population is therefore progressively smaller, while the level of risk to the individual is progressively greater: **(1) Universal, (2) Selective, (3) Indicated, (4) Relapse & Comorbidity Prevention.** The “Universal” stage describes facilitating healthy lifestyles rather than clinical treatment of dysfunction (19).

We created **Figure 2, Mental Disorders Prevention and the Clergy**, to educate mental health professionals about the roles of clergy across these prevention categories. It shows how the multiple professional roles of clergy mirror the four NIMH prevention categories: **(1) Universal:** Clergy understand the normative context of people's experience (4, 11); **(2) Selective:** Clergy—and their congregations—are sources of social and emotional support in times of stress (20); **(3) Indicated:** Clergy are de facto gatekeepers for persons who need assessment by a mental health professional to determine if they require clinical intervention and care (2); **(4) Relapse & Comorbidity Prevention:** Clergy provide community reinforcement for adherence to treatment. Religious organizations also provide support to families of persons with mental illness (9, 21).

We created **Figure 3**, *Clergy: A Mental Health Perspective*, to use in outreach programs with local clergy and lay congregation leaders. This single sheet allows us to visually and conceptually describe a hierarchy of mental health needs of persons in their communities. The sheet follows the NIMH prevention categories without using their technical language. The shading, the font color, as well as the content of the rectangles communicate when to collaborate. The diagram begins with an unshaded box, which recognizes the mental health support provided by the clergy and their congregations and acknowledges that these normative relationships do not require the presence of clinicians. The increased shading represents increasing severity of psychological distress. The switch from statements to questions, as well as of font color from black to white in the third box, represents situations that would involve contact with mental health clinicians by clergy.

The **first stage** described in Figures 2 and 3 recognizes that healthy adults may further their psychological well-being by taking part in the “*Generative*” activities of the church (synagogue, mosque, temple . . .) (22-24), and they may benefit from many other positive social support aspects of religious community involvement (25, 26). In the **second stage**, when there are emotional difficulties (e.g. a person bereaved by the loss of a spouse), the clergy and religious community provide social support that can help the individual cope (20). Depending on the wisdom traditions (27) and theological orientation of an individual’s religion; at this stage the congregation may provide faith-based rituals of support. These first two stages describe normative parts of the multifaceted duties of clergy (5, 28).

Epidemiological data show that bereavement greatly increases the risk of depressive episodes, which may well require clinical intervention (29). Clergy, as persons who regularly comfort grieving families, could be the first to recognize signs of clinical depression. At the **third stage**, the clergy could be instructed to call on the clinician’s expertise in order to determine if the congregant has a major depressive disorder or other clinical needs (30, 31). Now the parishioner may need to receive professional mental health care in order to reduce disorder and to regain function (32). In our dialogues with Christian clergy—and in national surveys of imams (33) and rabbis (34)—clergy recognized a distinction between bereavement and depression, but did not know how to collaborate with mental health professionals. The C.O.P.E. program is designed to provide *Burden Reduction* to clergy at this stage by facilitating referrals to clinicians.

In the **fourth stage**, the patients’ symptoms subside and function increases, but they remain at risk for relapse. At this stage, religious involvement can help persons both improve and maintain their mental health (35-38). It is an opportunity for what Rosen (39) calls, “*role restoration*” (p 23), and a return to the first stage. This may provide *Burden Reduction* to clinicians by diminishing relapse.

Summary

Our work follows the resource collaborator model and seeks reciprocal collaboration (8, 13). Our goals are the same as those described in an article on collaboration with clergy published over thirty years ago (40): “*Employ a nonthreatening avenue of approach*”, in order, “*to effect working referral relationships*” (p. 556). Through a *Religion Inclusive* approach we have facilitated collaboration between expert clinicians and a wide diversity of clergy including Armenian Orthodox; Catholic; Ethical Culture; Hindu; Orthodox, Conservative, Reconstructionist and Reform Jewish; Muslim; as well as evangelical and mainline Protestant.

In the C.O.P.E. model clinicians need not wait for clergy to initiate a dialogue. Clinicians can begin their own C.O.P.E. program by contacting local interfaith clergy groups and asking to attend their meetings. Clinicians could also begin a C.O.P.E. program by entering into a dialogue with the hospital chaplain (41). One can organize the collaboration discussions with the handouts provided here (Figures 2 & 3). The key to success is to develop ongoing reciprocal relationships (42-44), which can offer *Burden Reduction* to both clinicians and clergy.

To describe the C.O.P.E. continuity of care model, we use the term, “*Religion Inclusive*” rather than “*Faith-Based*”. The term *Religion Inclusive* incorporates the spectrum of care—as well as the breadth of collaborators—described above. We recognize that religion is not primarily a clinical activity (45, 46), and we recognize the importance of faith-based rituals of support for some religious persons’ emotional well-being (4, 47). We proffer that in the first two stages of C.O.P.E. (Figures 2 & 3), it is clergy who are the religious experts; it is clergy who in many traditions serve their congregations through an ordained vocation, and it is therefore clergy who best facilitate religious rituals. It is in the third stage of C.O.P.E. that clinicians who are experts in mental health care, would provide professional assessment and interventions to persons from religious communities. Regardless of the clinicians’ own religiosity, they can provide psychotherapy, which may be inclusive of religious themes, and could be informed by consultation with an individual patient’s clergy (with consent). In the fourth stage of C.O.P.E., clergy and clinicians use the expertise of each to prevent relapse.

Collaboration with clergy and religious institutions is an opportunity, not a panacea. Several projects, like C.O.P.E., have found positive outcomes through diversity-inclusive religious collaboration (40, 48-50). Yet, religious disappointment and struggles can harm a person’s well-being, manifested by anxiety, depression, suicidality and medical comorbidity (51-56). Certainly, it would be a mistake to uncritically seek collaboration if patients have such a history, or are in any way disinclined to inform their clergy of their treatment. We must assess and treat each patient individually, without an assumption that religion is good or bad (57).

Our collaboration with religious leaders has expanded the scope of our clinical work, and C.O.P.E. has shown great promise for improving the continuity of mental health care through *Burden Reduction* to both clergy and clinicians. Future research could further examine clinical outcomes of collaboration, and, where possible, compare the efficacy of different collaboration models facilitated with different populations, by an array of clergy and clinicians. Another goal will be to try to reduce stigma toward mental illness and increase the willingness to seek mental health care at the community level through intervention in churches (synagogues, mosques, temples . . .) (5, 58). C.O.P.E. describes a defacto system of care. It therefore could be useful to employ a *Systems Thinking* methodology for future studies (59-61).

In examining the clinical value of C.O.P.E., we return to our primary outcome measure for success: the emotional well-being of the persons in our collective care. Dissemination of an empirically validated model, which improves the continuity of mental health care through clergy outreach and professional engagement, could benefit millions of people who attend the more than 260,000 religious congregations across the United States.

References

1. Jones DE, Doty S, Grammich C, Horsch JE, Houseal R, Lynn M, Marcum JP, Sanchagrin KM, Taylor. RH: Religious Congregations and Membership in the United States 2000: An Enumeration by Region, State and County Based on Data Reported by 149 Religious Bodies. Nashville, TN, Glenmary Research Center, 2002
2. Wang PS, Berglund PA, Kessler RC: Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research* 2003; 38(2):647-73
3. Regier DA, Narrow WE, Rae DS, Manderscheid RW: The de facto US mental and addictive disorders service system: Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry* 1993; 50(2):85-94
4. Shifrin J: The Faith Community as a Support for People with Mental Illness. *New Directions for Mental Health Services* 1998(80):69-80
5. Milstein G, Kennedy GJ, Bruce ML, Flannelly K, Chelchowski N, Bone L: The clergy's role in reducing stigma: Elder patients' views. *World Psychiatry* 2005; 4(S1):26-32
6. Adair CE, McDougall GM, Beckie A, Joyce A, Mitton C, Wild CT, Gordon A, Costigan N: History and Measurement of Continuity of Care in Mental Health Services and Evidence of Its Role in Outcomes. *Psychiatric Services* 2003; 54(10):1351-1356
7. Bachrach LL: Continuity of care for chronic mental patients: a conceptual analysis. *American Journal of Psychiatry* 1981; 138(11):1449-1456
8. Pargament KI, Maton KI, Rappaport J, Seidman E: Religion in American life: A community psychology perspective, in *Handbook of community psychology.*, Kluwer Academic Publishers, 2000, p 495
9. Govig SD: *In the Shadow of Our Steeples: Pastoral Presence for Families Coping with Mental Illness.* New York, Haworth Pastoral Press, 1999
10. Jernigan HL: Pastoral Care and the Crises of Life, in *Community Mental Health: The Role of Church and Temple.* Edited by Clinebell HJ. New York, Abingdon, 1970
11. Ware NC, Tugenberg T, Dickey B, McHorney CA: An ethnographic study of the meaning of continuity of care in mental health services. *Psychiatric Services* 1999; 50(3):395-400
12. Kelly TA, Strupp HH: Patient and therapist values in psychotherapy: Perceived changes, assimilation, similarity, and outcome. *Journal of Consulting and Clinical Psychology* 1992; 60(1):34-40
13. Tyler FB, Pargament KI, Gatz M: The resource collaborator role: A model for interactions involving psychologists. *American Psychologist* 1983; 38(4):388-398
14. Milstein G: Clergy and Psychiatrists: Opportunities for Expert Dialogue. *Psychiatric Times* 2003; 20(3):36-39
15. Gorsuch R, Meylink WD: Toward a co-professional model of clergy-psychologist referral. *Journal of Psychology and Christianity* 1988; 7(3):22-31
16. Gordon R, Steinberg JA, Silverman MM: An operational classification of disease prevention, in *Preventing mental disorders: A research perspective.*, National Institute of Mental Health, 1987, pp 20-26
17. National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research: *Priorities for Prevention Research at NIMH.* Rockville, MD, National Institute of Mental Health, 1998
18. National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research: *Priorities for prevention research at NIMH.* *Prevention & Treatment* 2001; 4(1)

19. Seligman MEP, Csikszentmihalyi M: Positive Psychology: An Introduction. *American Psychologist* 2000; 55(1):5-14
20. Pargament KI: *The Psychology of Religion and Coping*. New York, The Guilford Press, 1997
21. Milstein G, Guarnaccia PJ, Midlarsky E: Ethnic Differences in the Interpretation of Mental Illness: Perspectives of Caregivers, in *Research in Community and Mental Health: the Family and Mental Illness*, vol 8. Edited by Greenley JR. Greenwich, CT, JAI Press, Inc., 1995, pp 155-178
22. Erikson EH, Erikson JM: *The life cycle completed*. New York, W.W. Norton, 1997
23. de St. Aubin E, McAdams DP, Kim T-C: *The Generative Society: Caring for future generations*. American Psychological Association, 2004
24. McAdams DP, de St. Aubin E: *Generativity and adult development: How and why we care for the next generation*. American Psychological Association, 1998
25. Gottlieb BH: Social support as a focus for integrative research in psychology. *American Psychologist* 1983; 38(3):278-287
26. Myers DG: The Funds, Friends, and Faith of Happy People. *American Psychologist* 2000; 55 (1):56-67
27. Hopkins E, Woods Z, Kelley R, Bentley K, Murphy J: *Working with groups on spiritual themes*. Duluth, MN, Whole Person Associates, 1995
28. Blizzard SW: The minister's dilemma. *Christian Century* 1956; 73:508
29. Bruce ML, Kim K, Leaf PJ, Jacobs S: Depressive episodes and dysphoria resulting from conjugal bereavement in a prospective community sample. *American Journal of Psychiatry* 1990; 147(5):608-11
30. Holmes CB, Howard ME: Recognition of suicide lethality factors by physicians, mental health professionals, ministers, and college students. *Journal of Consulting & Clinical Psychology* 1980; Vol 48(3):383-387
31. Weaver AJ, Koenig HG: Elderly suicide, mental health professionals, and the clergy: A need for clinical collaboration, training, and research. *Death Studies* 1996; 20(5):495
32. New Freedom Commission on Mental Health: *Achieving the Promise: Transforming Mental Health Care in America*. Final Report. Rockville, MD, Department of Health and Human Services, 2003
33. Ali O, Milstein G, Marzuk P: The Imam's Role in Meeting the Counseling Needs of Muslim Communities in the United States. *Psychiatric Services* 2005; 56(2):202-205
34. Milstein G, Midlarsky E, Link BG, Raue PJ, Bruce ML: Assessing problems with religious content: a comparison of rabbis and psychologists. *Journal of Nervous and Mental Disease* 2000; 188(9):608-15
35. Kennedy GJ, Kelman HR, Thomas C, Chen J: Religious affiliation and practice and depression among 1,855 older community residents. *American Journal of Geriatric Psychiatry* 1996; 4(4):349-349
36. Braam AW, Beekman AT, Deeg DJ, Smit JH, van Tilburg W: Religiosity as a protective or prognostic factor of depression in later life; results from a community survey in The Netherlands. *Acta Psychiatrica Scandinavica* 1997; 96(3):199-205
37. Koenig HG, George LK, Peterson BL: Religiosity and remission of depression in medically ill older patients. *American Journal of Psychiatry* 1998; 155(4):536-42
38. Milstein G, Bruce ML, Gargon N, Brown E, Raue PJ, McAvay G: Religious practice and depression among geriatric homecare patients. *The International Journal of Psychiatry in Medicine* 2003; 33(1):71-83
39. Rosen A: Destigmatizing day-to-day practices: what developed countries can learn from developing countries. *World Psychiatry* 2006; 5(1):21-24
40. Levenberg SB: Building consultative relationships with rural fundamentalist clergy. *Professional Psychology* 1976; 7(4):553-558

41. Milstein G, Sims E, Liggins L: Community Outreach by a Mental Health Center: A Dialogue with Clergy. *The Community Psychologist* 1999; 32(1):49-51
42. McMinn MR, Dominguez AW: Introduction, in *Psychology and the church*. Edited by McMinn MR, Dominguez AW, Nova Science Publishers, Inc, 2005, pp i-xiv
43. Meylink WD, Gorsuch RL: Relationship between clergy and psychologists: the empirical data. *Journal of Psychology and Christianity* 1988; 7(1): 56-72
44. Piedmont EB: Referrals and Reciprocity: Psychiatrists, General Practitioners, and Clergymen. *Journal of Health & Social Behavior* 1968; 9(1):29-41
45. Funder DC: Why study religion? *Psychological Inquiry* 2002; 13(3):213-214
46. Milstein G: [Review of the books *Handbook of Religion and Health* and *The Link between Religion and Health: Psychoneuroimmunology and the Faith Factor*]. *American Journal of Geriatric Psychiatry* 2004; 12(3):332-334
47. Sullivan WP: Recoiling, Regrouping, and Recovering: First-Person Accounts of the Role of Spirituality in the Course of Serious Mental Illness. *New Directions for Mental Health Services* 1998(80):25-33
48. Anderson RG, Robinson C, Ruben H: Mental Health Training and Consultation: A Model for Liaison with Clergy. *Hospital and Community Psychiatry* 1978; 29(12):800-802
49. Aten JD: Improving Understanding and Collaboration Between Campus Ministers and College Counseling Center Personnel. *Journal of College Counseling* 2004; 7(1):90-96
50. Budd FC: An Air Force model of psychologist-chaplain collaboration. *Professional Psychology: Research & Practice* 1999; 30(6):552-556
51. Goodstein L: Decades Of Damage; Trail of Pain in Church Crisis Leads to Nearly Every Diocese, in *New York Times*. New York, 2003, p 1
52. Krause N, Ingersoll-Dayton B, Ellison CG, Wulff KM: Aging, religious doubt, and psychological well-being. *Gerontologist* 1999; 39(5):525-33
53. Fitchett G, Rybarczyk BD, DeMarco GA, Nicholas JJ: The Role of Religion in Medical Rehabilitation Outcomes: A Longitudinal Study. *Rehabilitation Psychology* 1999; 44(4):333
54. Wolfe DA, Jaffe PG, Jette JL, Poisson SE: The Impact of Child Abuse in Community Institutions and Organizations: Advancing Professional and Scientific Understanding. *Clinical Psychology: Science & Practice* 2003; 10(2):179-191
55. Exline JJ, Yali AM, Sanderson WC: Guilt, discord, and alienation: The role of religious strain in depression and suicidality. *Journal of Clinical Psychology* 2000; 56(12):1481-1496
56. Hill PC, Hood RW: *Measures of Religiosity*. Birmingham, AL, Religious Education Press, 1999
57. Pargament KI: The Bitter and the Sweet: An Evaluation of the Costs and Benefits of Religiousness. *Psychological Inquiry* 2002; 13(3):168-181
58. Corrigan PW, Penn DL: Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist* 1999; 54(9):765-76
59. Stermann JD: Learning from Evidence in a Complex World. *American Journal of Public Health* 2006; 96(3):505-514
60. Midgley G: Systemic Intervention for Public Health. *American Journal of Public Health* 2006; 96(3):466-472
61. Leischow SJ, Milstein B: Systems Thinking and Modeling for Public Health Practice. *American Journal of Public Health* 2006; 96(3):403-405

Author Note

This research was supported by grants from: the DeWitt Wallace-Reader's Digest Research Fellowship Program in Psychiatry; the National Institute of Mental Health (T32 MH19132, RO3 MH64614-01A1); the American Psychological Association (ProDIGs); the City College of the City University of New York (PSC-CUNY). Correspondence concerning this handout should be addressed to Glen Milstein, Ph.D., Department of Psychology, The City College of the City University of New York, Convent Avenue at 138th Street; New York, NY 10031. E-mail: gmilstein@ccny.cuny.edu.

Figure 1: National Institute of Mental Health (NIMH) Prevention Science Categories with examples of types of prevention interventions.

NIMH, Level of Risk & Proportion of Population Receiving Preventive Interventions	
UNIVERSAL	
Target:	General Public or a Whole Population Group <i>Community involvement and social support to facilitate cognitive and emotional development.</i>
SELECTIVE	
Target:	Individuals or Subgroup of the Population at Risk <i>Programs for people experiencing major stressors, such as job loss, divorce, and natural disaster</i>
INDICATED	
Target:	High-Risk Individuals with Identifiable Signs or Symptoms <i>Therapy for persons with subclinical symptoms.</i>
RELAPSE & COMORBIDITY PREVENTION	
Target:	<i>Relapse prevention for persons with a Mental Health Disorder.</i>
<u>Adapted From:</u>	
National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research. (1998)	

Figure 2: Handout for Mental Health Professionals' "Inreach"

Mental Disorders Prevention and the Clergy	
Universal	
Clergy and religious congregations help to facilitate and sustain individuals' mental health by providing persons with the context & coherence of a caring social community, encompassed by shared religious beliefs & values.	
Context:	clergy interact with congregants across their lifespan both when they are and when they are not having problems.
Coherence:	religious communities provide comfort, support and meaning, which may help persons, both to foster healthy lifestyles, and also to regain their sense of belonging if they do experience a mental disorder.
Selective	
In response to Major Stressors (<i>e.g. job loss, divorce, natural disaster, bereavement, raising children</i>)	
religious communities help individuals prevent more serious dysfunction through:	
<ul style="list-style-type: none"> • Social Support from the Congregation • Enacting Community Rituals • Reinforcement of Religious Coping Beliefs • Brief Clergy Counseling 	
Indicated	
<ul style="list-style-type: none"> • Clergy and religious congregations could note if, in response to stress, individuals demonstrate a deterioration of functioning (<i>i.e. Bereavement can lead to Major Depression</i>). • If clergy have a collaborative relationship with mental health care providers, the clergy can intervene to initiate professional assessment and, if necessary, clinical treatment for the suffering individual. 	
Relapse & Comorbidity Prevention	
Clergy and congregations can help persons with mental disorders by facilitating the adherence to treatment that is necessary to prevent the recurrence of mental illness. Such support can also reduce the co-occurrence of comorbid symptoms and help reduce family burden.	
© 2008 Glen Milstein, Ph.D	

Figure 3: Handout for Clergy Outreach

Clergy: A Mental Health Perspective	
What You Already Do	
YOU	provide comfort, support and meaning, which can foster positive psychological attributes such as hope, perseverance and happiness.
YOU	interact with congregants both when they are, and when they are not, having problems.
How You Already Help	
<u>In Response:</u> to Stress (<i>job loss, divorce, natural disaster, bereavement, raising children</i>)	
<u>You Provide:</u>	
<ul style="list-style-type: none"> • Religious Coping Beliefs and Rituals • Social Support from the Congregation • Counsel 	
How Can You Help to Improve Care?	
Collaboration:	with Mental Health Care Providers to facilitate the referral of a congregant to a clinician for assessment and treatment (<i>e.g. if bereavement appears to have become depression</i>).
Education:	to reduce Stigma toward Mental Health Care.
What More May Need To Be Done?	
Reintegration:	into the Congregation.
Adherence:	to Mental Health Treatment Plan.
Support:	to Families of Persons with Mental Illness.
Prevention:	of Relapse and Possible Harm to Self or Others.
© 2008 Glen Milstein, Ph.D.	

