Reflection Paper:

Mental Health Issues and Recommendations

EqUUal Access

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Executive Summary

This paper is the result of a series of email exchanges between Rev. Peter Morales, President of the Unitarian Universalist Association, and EqUUal Access, a related organization of the UUA. In the days following the shooting of 20 children and eight adults in Newtown, Connecticut, on December 14, 2012, EqUUal Access began a conversation with President Morales about the stigma placed on people who live with mental illness, the roles the Unitarian Universalist Association and Unitarian Universalist ministers can play to confront the discrimination, the need for ministers to provide comfort and acceptance to those being marginalized, and the importance of the language Unitarian Universalists use about mental illness and those who live with it. President Morales invited EqUUal Access to write a reflection paper describing the issues and recommending actions.

As Unitarian Universalists, we have a tradition advocating for those who experience discrimination and prejudice; our work in the areas of anti-oppression/anti-racism/ multiculturalism initially focused on race, gender equality, and homophobia. In 1997, General Assembly passed a resolution titled “Accessibility for Persons with Disabilities.” The Association began to address discrimination against people with disabilities as well, adding ableism to the portfolio of oppression work.

Approximately 26.6% of the American population (57 million people) live with a diagnosable mental illness. Although many people who experience some type of mental disorder remain silent about their condition, clergy have reported to EqUUal Access that, following a worship service conducted on the topic of mental health, they were surprised by the number of congregants who revealed that they have experienced a mental illness in their own lives or have a loved one living with a mental health problem.

There is a long history of discrimination against people with mental illness. In the mid-1800’s, Dorothea Dix, a Unitarian, was one of the first to advocate for people with mental disorders, publicizing their inhumane treatment in institutions. Her work led to the creation of improved facilities. Today, people with mental illness are more likely to be homeless, lose their rights, and be stigmatized by the general public than those without

a diagnosed mental illness. African Americans, soldiers returning from the wars in the Middle East, prisoners, and members of marginalized communities are the most vulnerable to mistreatment.

Over the last thirty years, people with mental disorders have worked hard to receive improved treatment and services, primarily through self-advocacy and linkage to other civil rights efforts. The Recovery Model and Consumer Movement emphasize the autonomy of the individuals separate from their diagnosis, the need for an integrated life, support systems, peer relationships, and inclusion in social justice efforts. Their mantra has been “nothing about us without us.”

Although the prevailing perception, as fed by some in the media, is that people with mental disorders are more likely to be violent than those without a mental disorder, the truth is that having a diagnosis of mental illness does not make one more likely to commit an act of violence than anyone else.

The language we use is extremely powerful; we can contribute to the stereotypes, prejudices, and fear of people with mental disorders or we can speak with respect, compassion, and acceptance. Faith communities have a significant role to play in the public square and in our congregations, modeling behavior that is inclusive, affirming, and welcoming. We must all resist the temptation to use stereotypical notions of mental illness in written, email, social media, and other communications, particularly the idea that acts of mass violence are caused by people living with mental illness.

Studies show that inclusion in a spiritual community enhances the lives of those who live with mental disorders. Religious activity such as prayer, attending religious services, meditation or meeting with a spiritual leader is associated with reducing symptoms for those who experience a more severe form of mental illness.

There are a number of mental health initiatives underway throughout our Association. The EqUUal Access Mental Health Caucus and the Unitarian Universalist Mental Health Ministry are both led by Rev. Barbara Meyers, a community minister with Mission Peak

UU Congregation. She has developed resources, manuals, videos, a television show, and training modules all focused on educating religious and lay leaders on mental health issues. Unitarian Universalists have connections with national mental health organizations while also supporting individual congregations in their advocacy and education efforts.

EqUUal Access recommends a number of activities on which to collaborate with UUA leadership in order to confront the discrimination against, and to provide comfort and solace to, those who live with mental disorders. Public witness, denominational social justice initiatives, affirming statements from UUA leadership, ministerial education and demonstrated competency, and congregational worship services and workshops are examples of ways the UUA can distinguish itself in the public square as an advocate for those who live with mental disorders. Doing so will continue our tradition of living on the side of love, of respecting the inherent worth and dignity of all people, and valuing the interdependent web of life.

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A Story

The Unitarian minister László Kiss was the Francis Balázs Scholars Program scholar at Starr King School of Ministry 1998-1999. While there he recounted this story in one of his lectures.

Rev. Kiss was the minister in a small village in Transylvania. One day he visited a parishioner. He was shocked when he walked in and found people warehoused, stacked in unclean bunk beds several to a room, and how the general appearance of the facility was that it was a place for discarded human beings that no one wanted.

But the residents heard that he was coming and was going to do Holy Communion for his parishioner. They were all excited. They wanted to have Holy Communion, too. It became the most important thing in their lives that day that they would be able to participate in the ritual. They all lined up like children and waited patiently for their turn to have Holy Communion.

These were people who had been physically removed from the only society that they knew, a society that was based on very close social ties in a small village. They had been discarded, as if their lives didn't matter anymore.

And, yet when Rev. Kiss showed up with his communion cup, their faces lit up. God was still available to them. God was listening.

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Our Responsibility as Unitarian Universalists

Unitarian Universalists respect the inherent worth and dignity of all people. We advocate for those who are oppressed and we work to correct social injustices and discrimination against those who are marginalized by mainstream society. We have a long and proud history of giving voice to the prejudice against people of color, women, the GBLT community, immigrants, and many other alienated groups. When the 1997 General Assembly passed the resolution “Accessibility for Persons with Disabilities,” we affirmed that people with disabilities deserve that same commitment of advocacy, that people with disabilities are also targets of discrimination, individually and as a group. We began to understand that ableism is inextricably linked to racism, sexism, heterosexism, ageism, classism, and cultural chauvinism. As stated in the 2008 report to the UUA Board of Directors from the Journey Toward Wholeness Transformation Committee *Snapshots Along the Journey: Assessing Ministerial Cultural Competence*, “we note the intersections among these oppressions while recognizing that each oppression has its individual history, cultural context, and unique place in society.”

For Unitarian Universalist religious people, the commitment is two-fold. Ministers are trained to be meaning makers and givers of comfort and hope to those who are lost and in most need. As they become advocates for more humane care, they must also become our prophetic witnesses, inspiring us all from the pulpit to change society. These are among the best things the faith community can do to curb mental illness in others and ourselves. If mental illness is a cultural expression of mental suffering, then ministers and the UUA should become agents of cultural and social justice change to confront and eliminate that suffering and discrimination.

In being with people with mental disabilities, we need to learn to see the holy in their/our faces, and to accept them/us just as they/we are, with their/our limitations and pain and also with their/our gifts, and their/our beauty and their/our capacity to grow. In addition to providing comfort and care to those who live with mental illness, families, and friends, all Unitarian Universalists must also give public voice to the institutional oppression against those who are viewed as “mentally ill.”

Prevalence of Mental Illness: Nationally and in Our Congregations

About one in four American adults (57.7 million people or 26.6% of the adult population) live with a diagnosable mental disorder in a given year.[1] We are them and they are us. Ministers throughout the Association are beginning to address mental illness in their sermons and are seeing its incidence first hand. The Rev. Barbara F. Meyers, a community minister in California, frequently speaks to Unitarian Universalist congregations about mental health. After her sermon, she asks those assembled to rise in body or spirit if they or a loved one is living with a mental health problem. Eighty to 100% of the people rise. They are universally surprised that so many people are standing. It becomes obvious that there are many people suffering silently, either for themselves or for a loved one, and unwilling or unable to be open about it.

Many times, people come to worship services for hope and fortitude in dealing with their problems. The overt and internalized oppression they feel is so great as to keep many of them from seeking help that is effective and readily available to them, leaving them to live lives that are far below their dreams and potential.

[1] "The Numbers Count: Mental Health Disorders in America," National Institute of Mental Health, last reviewed February 4, 2013, www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml.

Oppression and Mental Illness

Dorothea Dix, a Unitarian and a parishioner of William Ellery Channing, was the foremost crusader for mentally ill people in the United States in the mid-1800's. Dix's career as a reformer began in 1841 when she visited a jail and noticed that there were some insane prisoners who were being kept there in deplorable conditions. Her instant compassion for them was the beginning of her life's calling. In 1843, her report *Memorial: To the Legislature of Massachusetts*, in which she presented the results of her survey of the state's insane people, gave many shocking details of how they were being treated. In many instances they were kept chained in an enclosed space, lying in their own filth, without adequate clothing, and abused physically and sexually. It was thought by many that they couldn't feel cold because their minds were deranged, and some were kept naked without heat, even in the winter. Through Dix's crusading efforts, things started to change. She eventually contributed to the start of 30 mental hospitals in the United States.

Over time, these "mental hospitals" did not receive adequate funding, and thus staffing shortages developed. In time, they became "snake-pits" and advocates clamored for their closing; eventually, institutions were replaced by placing people diagnosed with mental illness in a community setting, *e.g.,* group home, supported apartment. Again, the funding for community support was slow to materialize and inadequate. Today, many mentally ill people live on the streets or in jail or prison, a direct result of de-institutionalization.

It is shocking to learn that some prisoners are kept naked even today. A 2007 TV news story about mental health care in a Los Angeles jail[2] has footage of unclad prisoners in their cells. Bradley Manning, the leaker of Wiki-leaks who has a history of mental problems, has been kept naked in his cell.[3] This degrading treatment is shocking and

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[2] "Mentally Ill in Jail," video April, 3, 2007, www.youtube.com/watch?v=_N_FyIiPKcE.

[3] Courtney Kube, "Bradley Manning testifies about detention in Wikileleaks case," NBC News, November 29, 2012, http://usnews.nbcnews.com/_news/2012/11/29/15551532-bradley-manning-testifies-about-detention-in-wikileaks-case-i-totally-started-to-fall-apart?lite

certainly doesn't contribute to improving the mental health of the prisoners. It doesn't reflect well on our society that this continues to happen.

In 2006, the Human Rights Watch reported research from the *Harvard Civil Rights-Civil Liberties Law Review* concluding, "The failure of US prisons to address adequately the special needs of prisoners with serious mental illness ... flies in the face of international human rights standards." [4]

The situation today is not dissimilar to that when Dorothea Dix was alive. If she were to come back today, she might feel right at home. Prisoners aren't the only ones who are or have been oppressed because of their mental illness.

Some soldiers coming back from the wars in Iraq and Afghanistan are returning with serious psychological problems that are related to their service. Yet, too often, there is a lack of adequate treatment after they return. For a while there was a policy of wrongly classifying troubled returning soldiers as having pre-existing personality disorders, so they wouldn't have to be provided treatment. When this was widely publicized, the policy was changed. In recent months, the Veterans Administration has tried to meet the needs of returning veterans, but the problem overwhelms them and will get bigger.

Studies show that African American men are more likely to be over-diagnosed as having schizophrenia[5] and white men are more likely to be under-diagnosed as having mood disorders. There are far more African American men in our county's public psychiatric hospital, John George Psychiatric Pavilion, than their percentage in the general population." Having a diagnosis of schizophrenia will mean that people will be prescribed powerful anti-psychotic medication, have longer hospitalizations and are likely to be treated as if there is no hope for their living a full life.

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[4] Jamie Fellner, "A Corrections Quandary: Mental Illness and Prison Rules," Harvard Civil Rights-Civil Liberties Law Review, 2006, http://www.law.harvard.edu/students/orgs/crcl/vol41_2/fellner.pdf

[5] Michaeline Bresnahan, Melissa D Begg, Alan Brown, Catherine Schaefer, Nancy Sohler, Beverly Insel, Leah Vella and Ezra Susser, "Race and risk of schizophrenia in a US birth cohort: another example of health disparity?" *International Journal of Epidemiology*, Oxford University Press, downloaded April 1, 2013, http://ije.oxfordjournals.org/content/36/4/751.full.pdf+html

In an article exploring this issue in the Journal of Health and Social Behavior,[6] researchers state that, "A doctor who chooses to treat all patients the same regardless of race may make diagnostic mistakes to the extent that a patient's symptoms differ from the prototypical descriptions in the DSM (the Diagnostic and Statistical Manual). To change this, clinicians should make adjustments in how they reach a diagnosis (i.e., the questions they ask, the words they use, the type and amount of information they seek, etc.) on the basis of the patient's race." This takes special understanding and training that usually are not part of clinical education.

[6] Harold W. Neighbors, Steven J. Trierweiler, Brigett C. Ford, and Jordana R. Muroff “Racial Differences in DSM Diagnosis Using a Semi-Structured Instrument: The Importance of Clinical Judgment in the Diagnosis of African Americans,” *The University of Michigan, Journal of Health and Social Behavior* (2003) Vol 43 (September) 237-256.

Treatment Models and the Consumer Movement

The Medical Model [7]

In the medical model, there is thought to be a physical cause of the mental health problem. The symptoms are considered to be outward signs of the inner physical disorder and if symptoms are grouped together and classified into a syndrome, the true cause can eventually be discovered and appropriate physical treatment administered. The model assumes biological causes, pathology of the brain, germs or genes.

The medical model has been the most influential in determining the way that people with mental disturbances are treated. At best, it only provides a partial explanation, and may even be totally inappropriate, in some cases.

The Recovery Model [8]

Recently, there has begun a realization that while medical care is important and can be very helpful for some, it is not the whole picture. Other aspects of a person's life, such as socialization, intellectual learning, friendships, creativity, fun, spirituality, and having a meaningful occupation can be essential to improving lives. These are encompassed in a model called the Recovery Model.

Embraced in the last 10-15 years by mental health clients, families, providers, and the President's New Freedom Commission for Mental Health of 2003, the Recovery Model of mental health care is based upon the belief that people with mental illness can recover.

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[7] Jonathan Whittenhall, "The Medical Model of Mental Illness: Ethical and Practical Implicatons for Diagnosis," *Eye on Psi Chi: Winter 2007, http://www.psichi.org/pubs/articles/article_598.aspx*

[8] "The 8 Dimensions of Wellness," SAMHSA, last updated February 27, 2013, www.promoteacceptance.samhsa.gov/10by10/dimensions.aspx.

Recovery can be defined as:

- Regaining meaningful social roles in society as one grows beyond the catastrophic effects of mental illness.
- A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles.
- Maintaining as much freedom, independence and autonomy as possible, making as many decisions as possible for oneself including treatment options.

Recovery does not necessarily mean:

- The absence of symptoms.
- The absence of need for medication or other therapies.

Underlying assumptions of the Recovery Model:

- Recovery from severe psychiatric disabilities is achievable.
- Recovery is not a function of one's theory about the causes of mental illness.
- Recovery requires a well-organized support system.
- A holistic view of mental illness that focuses on the person, not just the symptoms.

One of the chief goals of the Recovery Model is to lessen stigma in society and also lessen the internalized stigma that can be so strong that people respond by hiding part of themselves to everyone else, themselves included. This response is not conducive to mental and physical health.

Part of recovery is having a spiritual sanctuary, including the support of a church community where people with mental illness may be supported in their healing.

The Consumer Movement [9]

The Consumer Movement, a mental health civil rights effort, has been instrumental in promoting the Recovery model.

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[9] "The History of the Mental Health Consumer/Survivor Movement," SAMHSA's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health, December 17, 2009, http://www.stopstigma.samhsa.gov/teleconferences/archive/training/teleconference12172009.aspx

In the 1960's and 1970's, social change movements were part of our culture. Inspired by the African American civil rights movement and civil unrest and resistance, women, the BGLT community, and people with physical disabilities organized for social change. At the same time, the big State mental hospitals across the country were being shut down, and new laws limiting involuntary commitment and its duration were being instituted. For decades, mental patients had been denied basic civil liberties, suffered systemic inhumane treatment, and spent lifetimes locked up in State hospitals.

Once released from these mental hospitals, people began meeting together in groups outside the hospital. These former "patients" shared feelings of anger about their abusive treatment and the need for independent living in the community. Their peers validated their feelings. From these isolated groups across the country, a new civil rights movement was born. It was predicated on the desire for personal freedom and radical systemic change; it was a liberation movement.

The decade of the 1970's was a time of finding each other and realizing that individuals were not alone, a time of militant groups and actions, a time of self and group education, and a time of defining core values. The consumer voice came out of the anger and hurt bred by the oppression of the mental health system. There was a period of separatism as a means of empowerment.

During the 1980's mental health consumers began the process of reentering the world again. New opportunities began, and, not coincidentally, some significant earlier endeavors ended. There were indications that many goals were beginning to be realized: a transitioning from words to deeds, conceptualizing to implementing.

The 1990's marked the fruition of changes that had been sought in the mental health system. Although the basic values remained the same, they were rephrased, given new priorities and emphases. Consumer/survivor-run groups, employment, and educational opportunities began to flourish. Attitudes began to change to recovery.

The 2000's have brought an increase to all of the gains of the 1990's. However, advocacy gains have created backlash, and service gains entailed compromises. The

consumer/survivor movement itself is becoming more diverse and inclusive and developing a national voice.

Principles of the Consumer Movement

All within the context of a liberation movement for people diagnosed with mental illness, the following were some of the principles these groups developed:

- Self determination and choice
- Rights protections
- Stigma and discrimination reduction
- Holistic services
- Self-help/peer-support programs
- Involvement in every aspect of mental health system
- “Nothing About Us Without Us”
- Concept of recovery (encompassing all of the above)

Mental Illness and Violence

There is a pervasive belief that mentally ill people are violent. Widespread media coverage of violent events that involve a mentally ill person plays a large part in this perception. Results of a recent study[10] by University of North Carolina researchers about mental illness and violence are shown on the following charts. They illustrate that people with mental illness alone are no more likely than anyone else to commit acts of violence. But mental illness combined with substance abuse or dependence elevates the risk for future violence.

"Our study shows that a link between mental illness and violence does exist, but it's not as strong as most people think," said Eric B. Elbogen, Ph.D., lead author of the study and assistant professor in the forensic psychiatry program at the University of North Carolina at Chapel Hill School of Medicine.

"We found that several other factors – such as a history of past violence or substance abuse or a recent divorce or loss of one's job – are much more predictive of future violence than mental illness alone," Elbogen said.[11] "Only when a person has both mental illness and substance abuse at the same time does that person's risk of future violence outweigh anyone else's."

UNC co-author Sally C. Johnson, M.D. added, "These findings challenge the perception some people have, and which you often see reflected in media coverage, that mental illness alone makes someone more dangerous. Our study shows that this perception is just not correct."

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[10] Eric B. Elbogen, PhD; Sally C. Johnson, MD, "The Intricate Link Between Violence and Mental Disorder Results From the National Epidemiologic Survey on Alcohol and Related Conditions," *JAMA Psychiatry, Vol. 66 No. 2,* http://archpsyc.jamanetwork.com/article.aspx?articleid=210191.

[11] "Mental Illness By Itself Does Not Predict Future Violent Behavior, Study Finds," *Science Daily,* February m3, 2009, http://www.sciencedaily.com/releases/2009/02/090202174814.htm.

Table 5. Most Statistically Robust Predictors in Final Multivariate Model of Any Violent Behavior Between Waves 1 and 2

Predictor	Wald *F*	*P* Value	Risk Domain
Age, y	136.746	<.001	Dispositional
History of any violent act	109.932	<.001	Historical
Sex	67.231	<.001	Dispositional
History of juvenile detention	31.007	<.001	Historical
Divorce or separation in the past year	28.154	<.001	Contextual
History of physical abuse	27.492	<.001	Historical
Parental criminal history	21.162	<.001	Historical
Unemployment for the past year	15.453	<.001	Contextual
Co-occurring severe mental illness and substance use	13.342	<.001	Clinical
Victimization in the past year	8.204	.003	Contextual

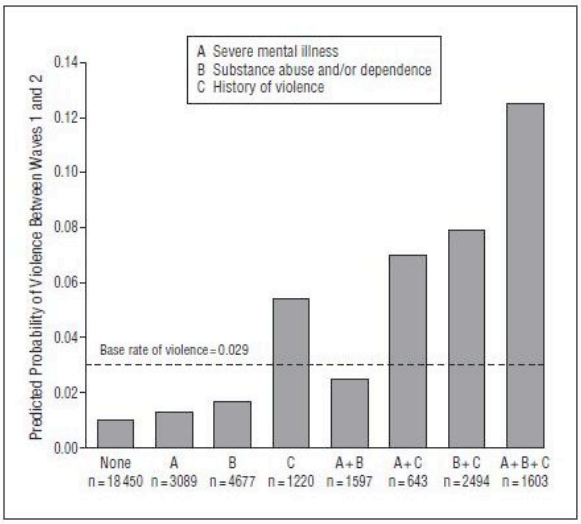

Figure. Predicted probability of any violent behavior between waves 1 and 2 as a function of severe mental illness, substance abuse and/or dependence, and history of violence.

The US Surgeon General's Report on Mental Health (1999)[12] says the following about violence: "Why is stigma so strong despite better public understanding of mental illness? The answer appears to be fear of violence: people with mental illness, especially those with psychosis, are perceived to be more violent than in the past. This finding begs yet another question: Are people with mental disorders truly more violent? Research supports some public concerns, but the overall likelihood of violence is low. The greatest risk of violence is from those who have dual diagnoses, *i.e.*, individuals who have a mental disorder as well as a substance abuse disorder. There is a small elevation in risk of violence from individuals with severe mental disorders (*e.g.*, psychosis), especially if they are noncompliant with their medication. Yet the risk of violence is much less for a stranger than for a family member or person who is known to the person with mental illness. In fact, there is very little risk of violence or harm to a stranger from casual contact with an individual who has a mental disorder. Because the average person is ill equipped to judge whether someone who is behaving erratically has any of these disorders, alone or in combination, the natural tendency is to be wary. Yet, to put this all in perspective, the overall contribution of mental disorders to the total level of violence in society is exceptionally small."

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[12] "Mental Health: A Report of the Surgeon General," U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS

Power and the Importance of Language

Language has the power to hurt, perpetuate stereotypes, and alienate those who need help the most. Recently, the Associated Press Stylebook broke new ground by publishing guidelines for reporters writing about mental illness and autism.[13] They recommend that mental health disorder diagnoses – autism, bipolar, schizophrenia, or other mental disorders - not be included in the story unless it is relevant to the story and appropriately sourced. In addition, when the diagnosis is confirmed and relevant, it encourages reporters to be specific as possible about the diagnosis, including examples of symptoms. In addition, when the diagnosis is confirmed and relevant, it encourages reporters to be specific as possible about the diagnosis and to include examples of symptoms. Finally, the guidelines urge reporters to refrain from using words like crazy, deranged, insane, or nuts, and to make no assumptions that mental disorders are associated with violent crime.

As advocates for those who are marginalized and as those who would be expected to provide comfort, hope, and acceptance, it is imperative that our Association, ministers, and leaders understand the impact of language, what is hurtful, and how to model comfort, hope, and acceptance. In public and within their congregations, ministers and other religious figures in authority must be aware of the language they use. If not intentional in their language, ministers and Association leaders can inadvertently contribute to stereotyping, stigmatizing, feeding prejudices, and discouraging treatment as well as preventing those who need solace from their pastoral counselor to seek it.

Here is an example of a statement, made in response to the Newtown tragedy, which feeds and inflames negative public perceptions of those with mental illness:

“How many more copycats are waiting in the wings for their moment of fame — from a national media machine that rewards them with the wall-to-wall attention and sense of identity that they crave — while provoking others to try to make their mark? A dozen

[13] Associated Press, “Entry on mental illness is added to AP Stylebook,” Press Release, March 7, 2013, http://www.ap.org/content/press-release/2013/entry-on-mental-illness-is-added-to-ap-stylebook

more killers? A hundred? More? How can we possibly even guess how many, given our nation's refusal to create an active national database of the mentally ill?" [14]

Contrast the above statement, with the one below:

"Let us ever deepen our capacity for compassion and comfort in the face of grief and loss. Let us develop more fully an understanding of the violence among us, and the effects of trauma in our lives – that we may become more loving and caring in our homes and neighborhoods, communities and world. Let us redouble and expand our efforts to learn about the most complex and wondrous organ in our bodies – our brain – that we may extend our love and care to include especially individuals and families who struggle with severe and persistent mental health issues." [15]

Focusing on use of language is a good place to start addressing social exclusion and discrimination against people with mental illnesses. Some sources for appropriate language around mental health issues are:

- "Language," SAMHSA's (Substance Abuse & Mental Health Services Administration) Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health (ADS Center) has collected a number of books, articles, fact sheets and organizations on language and mental illness.
- "Quick Tips to Improve Mental Health Reporting: Reporting on a Story That Includes Both Violence and Mental Illness" has excellent advice on how to write about situations involving violence and mental illness.

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[14] "NRA: Full Statement by Wayne LaPierre in response to Newtown Shootings," the Guardian, December 21, 2012, http://www.guardian.co.uk/world/2012/dec/21/nra-full-statement-lapierre-newtown

[15] Rev. Craig Rennebohm, Executive Director of Pathways to Promise, http://www.pathways2promise.org/index.htm

The Importance of Religion to People with Mental Health Problems

Recent studies suggest that religious activities and beliefs can be particularly important for persons who are experiencing more severe psychiatric symptoms. Increased religious activity such as prayer, attending religious services, meditation or meeting with a spiritual leader, is associated with reducing those symptoms. A California Institute of Mental Health[16] study surveyed people with mental health disorders and reported on the value of spirituality in dealing with mental illness. Research over the past several years has established that when there is a healthy understanding of what is needed to maintain mental wellness, an integration of spirituality can be beneficial in recovery. In fact, these studies have shown that clients/consumers experience: shorter recovery times, fewer relapses, and fewer hospitalizations when their faith/spirituality practices are embraced.[17]

The second principle of the Unitarian Universalist Association call us to justice, equity and compassion in human relations. Society, however, has not treated people deemed mentally ill with such regard. Historically, the graves[18] of patients who died in mental hospitals weren't marked. Elderly and mentally ill people have been denied the ability to worship, especially at a time in their lives when faith could be most helpful. Prisoners are kept naked and prisons are our new mental asylums. African American men are disproportionately diagnosed with schizophrenia. Soldiers returning from war aren't getting adequate care. People are being given electroconvulsive therapy (ECT) without their consent. Other major issues in the mental health field today include the mental

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[16] "Survey of Individuals Receiving Mental Health Services and Their Families," California Mental Health & Spirituality Initiative, Center for Multicultural Development, California Institute for Mental Health, 2008. www.mhspirit.org/uploads/Statewide%20CI%20Family%20Survey%20Report.pdf.

[17] "Mental Health & Spirituality TRAINING SERIES offered by the California Mental Health & Spirituality Initiative," Center for Multicultural Development, California Institute for Mental Health, March 2011, www.mhspirit.org/uploads/2011-06_MT_MH&Spirituality_for_Spiritual_Leaders.pdf.

[18] Amanda Marshall, "He adds names to lost graves of the mentally ill," Today American Story, June 2, 2009, www.today.com/id/31127332/site/todayshow/ns/today-today_news/t/he-adds-names-lost-graves-mentally-ill/#.US1BOaUsmp0.

health of LGBT youth,[19] mental health in children in foster care,[20] sub-standard board-and-care facilities,[21] people with mental illness have a life-span 25 years shorter than the general population,[22] and many people with severe mental illness are heavily drugged and do little but smoke and watch TV all day. These are people who our society has somehow decided don't matter.

Our Unitarian Universalist faith teaches us that each person has inherent worth and dignity. Nobody has the right to take away hope from people who need it the most. We have a religious obligation to change these scandalous situations.

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[19] "One Third of LGBT Youth Suffer Mental Disorders, Chicago Study Finds," Science Daily Dec. 2, 2010 www.sciencedaily.com/releases/2010/12/101201124355.htm

[20] "Assessing the Effects of Foster Care, Mental Health Outcomes," the Casey National Alumni Study, www.casey.org/Resources/Publications/pdf/CaseyNationalAlumniStudy_MentalHealth.pdf

[21] Senate Bill 258 – Chesbro (D-Acadia), "California Board and Care Reform bill," April 2005, www.californiaclients.org/pdf/NewsAlertApril2005.pdf

[22] "Why Wellness Matters for People with Mental Health and Substance Use Conditions," *Substance Abuse and Mental Health Services Association (SASHA*), last updated February 29, 2013, promoteacceptance.samhsa.gov/10by10//

Unitarian Universalist Mental Health Ministries

Unitarian Universalists are active in mental health efforts in several different venues across the Association.

Mental Health Caucus of EqUUal Access

The Mission of the Mental Health Caucus of EqUUal Access is to serve people with mental health difficulties and their families by:

- Advocating to eliminate their isolation and marginalization in congregational life and in society
- Reducing ministerial burdens through enhanced pastoral care co-ministry
- Increasing congregational knowledge of local mental health resources
- Promoting mental health work in Unitarian Universalist context using our Caring Congregations curriculum

As one of the caucuses of EqUUal Access, a collective of people with various disabilities and their allies, our focus is on mental health issues. In consonance with our first principle, we strive to counter these negative forces, with love and compassion, understanding, advocacy and acceptance in our religious communities.

We accomplish our mission through the following actions:

- Addressing obstacles to full participation in all Unitarian Universalist activities for those with mental health challenges.
- Educating ministers and congregations about mental health challenges in pastoral care, participation, and behavioral covenants.
- Developing and advocating for mental health accessibility policies and practices that endorses and ensures the full inclusion of people with mental health issues in a non-discriminatory manner.
- Affirming the spiritual gifts and needs of those with mental health issues.
- Helping congregations to identify and use local mental health resources that support Unitarian Universalist beliefs.
- Advocating for these social justice causes in local, regional and national venues.

- Encouraging all people with mental health issues and their allies within the denomination to join in this effort.
- Promoting the Caring Congregation curriculum to help accomplish these tasks.

Unitarian Universalist Mental Health Ministry

The Mission Peak Unitarian Universalist Congregation has a mental health ministry led by the UU community minister Rev. Barbara F. Meyers. This ministry has adopted the following:

1. Mission - to give compassionate help to people with mental health challenges and to their families, within and beyond the walls of our congregation.
2. Vision - to increase their hope, knowledge, and insight and help them find a sense of meaning in their lives.
3. Strategy - using fellowship, education, advocacy in the public arena, and honoring and deepening their spiritual lives.

The activities of the ministry are in four areas:

1. Education - The curriculum "*The Caring Congregation Handbook"* by Barbara Meyers is a program for educating a congregation about how to be more intentionally supportive of people with mental disorders and their families. To find out more, see Caring Congregation Curriculum.
2. Healing - Provides assistance for Pastoral Care, especially for people with mental disorders and their families and participates as tge assistant manager of the Reaching Across organization, a peer-run mental health drop-in center in Fremont.
3. Social Justice - Participates in community mental health activities, advocating for the mentally ill. The major projects in this area are creation and production of a public access TV program called Mental Health Matters, and a series of YouTube videos called Stories of Recovery.
4. Priestly Functions - Leads worship services at the Mission Peak Unitarian Universalist Congregation and other congregations, chiefly focusing on mental health-related topics.

National Interfaith Mental Health Leadership

Robert Skrocki, a member of the DuPage Unitarian Universalist Congregation in Naperville, Illinois, has become the Chair of the Board of Pathways to Promise, an interfaith cooperative of many faith groups that provides assistance and a resource center which offers liturgical and educational materials, program models, a caring ministry with people experiencing a mental illness and their families. He has been active in helping to organize interfaith mental health activities in the Chicago area.

Congregational Mental Health Efforts

In an article “The Mental Health Ministries,” the UU publication *Interconnections* highlighted mental health activities within several congregations in the UUA. The activities involve education, referrals, pastoral care and putting on local conferences focusing on mental health and faith.

Recommendations for Collaboration Between UUA Leadership and EqUUal Access

EqUUal Access recommends that we work together with UUA leaders across the Association to demonstrate and implement the UUA's commitment to become a prophetic voice in the public square on mental health issues through denominational advocacy and social justice initiatives, ministerial education, and congregational efforts. The following are suggested objectives and goals for our collaboration.

Denominational level commitment:

Goal - Unitarian Universalism is known as a leader in advocating for a mental health agenda.

- Issue public statements of advocacy and support from the President and leadership.
- Invite a nationally known mental health advocate to be a Ware Lecturer.
- Support *Pathways to Promise* with a denominational membership.
- Publish articles in *UU World* and *Interconnections* about mental health and religion.
- Lead denomination-wide advocacy/social justice efforts for mental health causes.
- Work with UUA Communications staff to ensure that Unitarian Universalists and Unitarian Universalist institutions use appropriate non-stereotypical language when referring to people with mental illness in written, email, social media and other communications.
- Use the information provided by AP Stylebook entry on mental illness when reporting and writing on mass violence.

Educate ministers:

Goal - Unitarian Universalist ministers know how to provide support to those living with mental disorders.

- Make education of mental health issues a requirement for ministerial fellowship.
- Conduct a survey of UUA ministers about mental health competency.
- Educate ministers at retreats and workshops based on results of survey.
- Encourage Mental Health Sermons, public statements, and social justice work on mental health issues.

Educate congregations:

Goal - Unitarian Universalist Congregations become places of support and understanding.

- Make sermons and services on mental illness available to ministers and congregations.
- Provide guidance to congregations wanting to start a mental health ministry.
- Encourage congregations to become knowledgeable about mental health issues by providing resources and references.

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