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Transcript of National Catholic Partnership on Disability

October 10, 2007

Presentation

THE MODERATOR: At this time all participants are in a listen-only mode. A brief question-and-answer session will follow the formal presentation. If anyone should require operator assistance during the conference, please press star zero on your telephone keypad. As a reminder, this conference is being recorded. It is now my pleasure to introduce your host, Ms. Dorothy Coughlin, director of the Office of Persons with Disabilities in Portland, Oregon. You may begin.

>> Welcome, everyone. On behalf of the National Catholic Partnership on Disability, I want to thank you for your participation in this webinar supporting people with mental illness in your parishes. It gives us great hope that so many people today are taking the time to increase their understanding of mental illness in an effort to grow in our ability to help create faith communities that offer support and hope to people who live with mental illness and their families. If for any reason you're having difficulty viewing or hearing this webinar, please click Q and A, select new, and then specifically describe your need. Or you can call 1-888-523-2450 and ask for technical support. This webinar today will consist of a 40-minute presentation followed by a live question and answer period in which you can access information from the presenters that specifically address your concerns. You are able to ask questions any time throughout the webinar by simply clicking Q and A, then click new, and then type your question. We're grateful to have with us as presenters for this event two experienced pastoral professionals in the field of mental health. Dr. Thomas Welch is a psychiatrist in private practice in Portland, Oregon, and a member of Saint Phillip Neri parish. Dr. Welch is the chair of the Interfaith Council on Mental Health here in Oregon and a member of the NCPD Council on Mental Illness.

Sister Sharon Collver is a chaplain at Oregon state hospital that serves people with serious mental illness. Sister Sharon is also a member of the Interfaith Council on Mental Health. Now let us begin. Dr. Welch.

>> Thank you, it's my pleasure and honor to be with you today. I understand we have over 50 different sites logged in and some sites may have more than one person. That is just wonderful to be able to spend some time with you today talking about this important situation. There's my picture. Sharon, unfortunately, doesn't have a picture. So we're going to have to imagine her or imagine her in the logo. But you can stare at me for a little bit since I can't stare at you.

To get started, I thought it would be helpful if we get a sense where people are across the country. We'll do our first poll. And this is an interactive poll. If you would just

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click on the screen next to the time zone in which you are participating then press the vote button. In a second I will display the results.

So wherever you are, we hope today's presentation will provide you with some new information. Maybe pose some challenges to you and stir your imagination to come up with some new and creative ideas to support people with mental illness in your parishes.

So let's see. Here comes the poll results. As we expected almost everybody is in the eastern daylight time zone. I should say afternoon. And some in central and here we are in the Pacific daylight time zone. I understand there are quite a few people from Georgia participating—we want to give a special welcome and good afternoon to those people. Why are we having this presentation in the first place? As we know parishes need to know about mental illness—everyone. Because within the parish, family and friends are dealing with mental illness. It is a very common situation that parish staff, including clergy, secretaries, janitors, are often the first responders to people experiencing mental health crises, and parishes are often the first places people will go when they're in need of some sort of assistance when they're dealing with a mental health situation.

Now to find out how many people are learning about this topic today. If you can take part in the next poll, let us know how many people are participating from your site. And submit the vote. Then we'll be able to get a sense of how many groups are out there. Then we'll begin with just some foundation material, background material on what mental illness is so that we can kind of move forward with a common vocabulary and common language.

So let's see. The majority of people are watching by themselves. And we do have some small groups and it looks like one little bit larger group. That is great. And I just realized that I didn't show those to you. There we go. Now you should see that. I'm sorry. The previous poll I guess I didn't show. But the majority of people were in the eastern time zone. Sorry about that. Moving down to the foundation, the background information of mental illness. What do we mean when we talk about mental illness? There are many conditions that can occur at any age and to anyone. There's a range of severity. And mental illness encompasses biological, psychological, social and spiritual dimensions of the individuals affected. And because mental illness affects all those domains we need to be attuned to all those domains and gear our response and our support to them. Today we're going to be focusing on what is referred to as severe and persistent mental illness. (Abbreviated SPMI.) It refers to conditions like schizophrenia, people who have chronic recurrence of hallucinations or delusions or disorganized thinking or behavior. There's bipolar disorder, which is commonly referred to as manic depressive illness or manic depression or schizoaffective disorder, hybrid of schizo-affective and bipolar disorder. There are illnesses that are sometimes included in the category of severe and persistent mental illness, some types of major depression, OCD and PTSD.

For the purposes of our discussion today we won't be considering intellectual disabilities, dementia or substance abuse disorders as severe persistent mental illness but they can occur in these people. Someone with schizophrenia might have

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alcohol abuse. Someone with bipolar disorder may at some point in late life develop Alzheimer's disease. There can be an overlap and co-occurrence.

The reason I'm making a point about the specific diagnosis is not to label or criticize a person using those diagnoses, but that it's important in directing treatment, because treatment and response will vary based on the person's diagnosis and their condition. Based on that condition we can do a better prediction of what the course of the illness will be and what the person's prognosis will be.

I'd like to spend a minute talking about a couple of types of symptoms that can occur in people with severe persistent mental illness. The first are psychosis, delusions disorganized speech catatonia and negative symptoms. I'll focus on the first two, which are most characteristic. Psychotic symptoms can be present in a lot of other disorders, a lot of other conditions. Someone who is intoxicated with alcohol or using drugs may have hallucinations. This doesn't mean they have schizophrenia or severe and persistent mental illness. The term psychotic doesn't refer to a person's character. It's one of those misused words. It has a very specific meaning, and refers to alterations in someone's thought process. And schizophrenia again is often a misused term. It doesn't refer to a split mind; isn't a split personality. People with schizophrenia have a specific constellation of symptoms and features.

Most commonly hallucinations present a sense of reality. The person can feel as if they're actually hearing, seeing, smelling, tasting or being touched, but there really isn't any source of that. Within the hallucinations, the most common type of hallucinations are auditory hallucinations. People can have a sense of a voice inside their head, a voice coming from outside their head, as if someone were talking to them, as if someone is really there. People are hearing their own thoughts, their thoughts are being projected, yet they think people are stealing their thoughts or inserting thoughts in their head.

Unfortunately, hallucinations are often demeaning or critical, but occasionally they can be pleasant. A person may actually like the hallucinations which can be a barrier to participating in treatment. To lose that pleasant hallucination might mean losing what seemed like a friend to them. So turning to our tradition, we have an incredibly astute saint, Saint Theresa of Avila, who in the late 16th century wrote very detailed descriptions of auditory hallucinations and experiences in her Interior Castle. She referred to locutions, sort of an auditory gift from God or message from God that can occur in the advanced stages of the spiritual journey, her sixth mansion, seventh mansion. But in referring to locution she was clear to say there were a lot of other types of auditory perceptions that weren't locutions, weren't as she said “of God.” She described that most of the time when people had these sort of experiences it was from a fancy and not from God. And that it was usually due to real melancholy or feeble imaginations which I think was a wonderful display of Theresa's ability to realize that some people had depression, real melancholy, severe depression. People can have psychotic symptoms, including hallucinations and feeble imaginations. It could be what we would call schizophrenia or a manic episode. With sisters in her convent, young adults at the time when mental illnesses often start to manifest themselves, she was able to distinguish between the mentally ill sort of symptoms versus the religious experience. And she was very compassionate in her description of how to work with

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people who were having the nonlocutions, having the hallucination. They should be treated with compassion and as anyone else with mental illness they should be given rest and one shouldn't argue with them in trying to tell them what they were experiencing wasn't real. It wouldn't work. It's okay to say to someone, “try not to think about those voices or those signs,” because if it was truly from God, God isn't going to go away. And if it was from fancy, the fancy hopefully would go away. So it's a nice distinction between what was kind of a rare extreme religious experience versus what would be more commonly the result of a mental illness. We have a new poll. Who is the patron saint of people with mental illness? It's no fair, you can't pull down the lives of the saints off the shelves because God is watching for cheaters. So tell us who it is. You can tell that the feast is in the month of May. Okay. I'm not going to—oh my goodness, look at this, 18 people. I need to publish the results. Smart group. Eighteen people—no, 25 people knew it was Saint Philip Neri that was the patron saint. St. Philip Neri happens to be one of my favorite saints and patron of my parish. In addition to being the patron of Rome he's called the saint of joy. It's a wonderful quality in a saint. He played practical jokes on the rich. Saint Mathias is considered the patron saint of people with alcohol problems. Another worthwhile saint is Saint Bona. Her claim to fame is that Pope John XXIII named her saint of flight attendants. Next time you're on a flight with poor service make an intercession to Saint Bona.

Let's talk a moment about another type of psychotic symptom and then we'll go on to the response of the parish. So delusion is a firmly held false belief. People are making an incorrect inference about reality and it's not widely shared by others in one's culture. That's important because there is a culture within our church and within other faith communities and religious experiences; religious expression may differ from church to church. And it's important to know whether someone's behavior, what they're saying is actually different from what is the typical behavior within their church. For some people that might be a very normal expression, whereas in another community, that would be considered different or beyond the normal situation. And there are different types of classifications of delusions based on the content of the mistaken belief.

The other domain that is affected in people with mental illness is mood. Sometimes called affect. It's emotions. People can be depressed or blue. They can be irritable. They can have a lack of emotions or lack of an expanded, expansive, euphoric emotional state. For someone to have a depressive episode or be affected by what we call a major depressive disorder, they have to have the depressed mood or sad mood. But they also have to have several of these features. Some alteration in their appetite and weight. Difficulty sleeping, sleeping too much. Not sleeping enough. Trouble concentrating. Losing interest in activities that had previously been enjoyable or interesting for them. Feeling fatigued, restless, lethargic, and having feelings of worthlessness and sometimes thoughts of death even to the point of having thoughts of committing suicide. On the other end of the mood spectrum are manic symptoms. So someone would have an elevated mood or maybe an irritable mood along with being kind of grandiose. Not needing to sleep at all. Talking a lot and racing thoughts and engaging in dangerous and risky behaviors. Regardless of the symptoms a person has, there are a variety of responses. Looking at the four dimensions, we need to pay attention to all four dimensions. In the biological dimension, medications

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are often helpful in people with mental illness. And so is getting general medical care and getting primary healthcare, making sure there aren't other healthcare conditions. Particularly thyroid can make a big difference in someone's mood as well as general diet and exercise. In the psychological realm, psycho therapy interventions improve quality of life. In the social dimension, support from the person's family as well as support to the family with mental illness is very important. Employment has been shown to be very therapeutic. It helps people with mental illness grow just in their own self-worth and quality of life. That may require supported employment or vocational rehabilitation services, and socialization and friends.

In the spiritual dimension, there are many different ways that we can respond. There's the parish community as a whole. There's sacraments and prayer and scripture and Sister Sharon in a bit will talk about one particular approach she has found helpful in the hospital setting as far as responding with prayer. So here are some things you can do in your parishes. You can attend, welcome, include, accommodate, pray, learn and teach and know. We'll go through these. So pay attention. I say that not to make sure you've not fallen asleep but to remind us we get tunnel vision— we get used to seeing our friends at mass, our groups and we forget to look at the broader community to see who really is coming to mass, who is coming to church. Maybe more importantly who isn't there. Maybe there's someone who previously had been there and has not shown up for weeks because they're so depressed and lethargic, they just can't get out of the house. So be mindful of that and make efforts to reach out to people.

It's important to see how the parish reacts when a new person comes in. How do they respond to someone who maybe looks different from the rest of the parish or maybe acts differently? And how can the parish, in that attention, respond in a spirit of hospitality? Welcoming everyone, (not just ushers and greeters offering welcome) but everyone in the parish as well as church buildings. Within the church property we can send messages that are unwelcoming or welcoming. Welcoming might be a poster from the national alliance on mental illness. It might be an announcement about a support group. It gives a message this is something that we talk about around here and that we support. Signs that say "no mumbling during mass" or "don't park your shopping cart outside the door" don't give a sense of welcoming. Those are sort of extreme examples. I think hopefully you're getting the crux of what I'm saying. And then invite people with mental illness to participate in parish activities. Don't assume an announcement in the bulletin or from the pulpit is enough to get someone involved. They may need a personal one-to-one invitation to come to an event or to volunteer for the pancake breakfast or dinner. There are ways to include people and ways to build in relationships and it's an important part of the parish community to build the relationships. Using person-first language is another good way to include people. What I mean by that is when we talk about people, we focus on the person first. So a person with a mental illness versus mentally ill. We could talk about the parishioner who is dealing with depression rather than the depressed parishioner because the language is powerful and even subtle changes in the wording communicate very strong messages including or excluding someone. It's important to encourage parishioners to bring family members to mass. Some may feel embarrassed if they have an adult child living with them that has a mental illness; they may do something

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or say something that will attract attention. So be welcoming and let them know they have a place.

And then companionship. This is an area that Reverend Dr. Craig Renenbaum out of Seattle is promoting. I'll give you a reference to that later. His residency program trains people to become companions to people with mental illness particularly in the faith community.

Then accommodation. I use the analogy of arthritis or lung disease. In our parishes there are people who probably have severe lung problems. They may come to mass wearing an oxygen tube in their nose and carrying an oxygen tank. They may cough during mass. They may wheeze.

I suspect that in most parishes people would be kind to them. They may ask them “is there anything we can do, can we help you with this? Can we get you a drink of water?” The same thing occurs with arthritis—someone may come in stumbling over the kneeler, have trouble getting up from the pew or drop their cane. I suspect in most parishes people would assist them, asking “Can I give you an arm up or help you up? Let me put your cane back up over the back of the pew.”

Unfortunately, that doesn't always happen to people who have mental illness. People with mental illness may have symptoms that include pacing around, particularly if they've been on anti-psychotic medications. They really can't sit comfortably or stand comfortably in one place during mass because they have such a discomfort that they have to keep moving.

People may mumble during mass. They may respond at the wrong time or be out of sync with the rest of the order of mass. And their appearance may be different. I'm hoping that we can move to a point where in our parishes if we see someone who is wearing headphones or an iPod, that we don't say, “Take those earphones out of your head. You're being disrespectful,” just as we wouldn't say to someone with lung disease “Take that oxygen off your nose, you're being disrespectful for that.” Because for someone hearing voices having ear plugs in may be the only way they can drown out the voices and attend to what's going on in mass and actually be present. So it would actually be hurtful to tell someone to do that.

Accommodation doesn't mean acquiescence, it doesn't mean that anything goes. There are many expectations that apply to everyone regardless of their abilities or conditions. Inappropriate and dangerous behavior really has to be pointed out primarily so the person has the opportunity to correct it. Some people don't have those self-monitoring skills to know when they're doing something that is inappropriate, and pointing that out to them gives them the opportunity to change it.

Rather than, you know, shaming them or being accusatory, you say this is an opportunity to change. And praying. That's what hopefully we are all good at in our communities, are experts at. We can pray for people with mental illness in our own personal intentions as well as including items in the prayers of the faithful but we also pray for people with mental illness at mass and prayer groups. Sister Sharon will be talking about ways of praying with in a hospital setting. Messages in the homily can

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be included that describe mental illness, describe challenges, and point out the justice issues that can arise in people with mental illness.

And also I think there's an obligation on the homilist to point out when the scripture reading gives a poor portrayal of someone possessed by demons, for instance, to make it clear that's not talking about having a mental illness. Or when the reading about "if your eye offends you pluck it out," to really tease that apart, because unfortunately that has been the source of some horrible actions in people who have psychosis. Most importantly is the message of **hope**—that what we are about is hope. That we are looking toward the future, and that we know there's a promise of much greater and wonderful things and that things always do get better. Within the parish we need to learn and teach. Now you have an opportunity to teach something. This can be done in a workshop or parish. If have you a parish nurse, health fair, screening day, hosting a NAMI group or support group is a wonderful way to provide education and support but to demonstrate that your parish is a welcoming community; that you want to have people with mental illness and their families come and feel comfortable on your grounds.

Faith formation is important in the sense that there may be adult faith formation, courses that can include topics on mental illness and also that RCIA programs may sometimes have to be modified for people who have severe and persistent mental illness, they can participate because they do have the desire for that faith and becoming a Catholic, even though they may not be able to sit through the typical program of RCIA. Peace and justice communities can examine issues with people with mental illness as it relates to poverty and homelessness, which, unfortunately, often occur together with someone with mental illness.

In our parish we've done that. We've had both discussion groups and showing of videos about mental illness and then having some discussion afterwards. And that has been very well received, very accepted.

So after you've learned and taught you need to know. It's important to know what the local resources are for emergency responses, if something really out of your control, out of your expertise comes up, some people have mobile mental health response teams that can be called out to do an assessment. Most places it's the police who come out. Some police are trained in crisis intervention and are very good at interacting with someone with a mental illness. Unfortunately in a lot of places police don't have this training. So it's important to ask around. Find out what people's experience has been so you can direct your experience. For people who maybe aren't in crisis but need services, it's important to find out what your local options are for mental health services, and usually across the country every county has some sort of mental health authority that may be a free-standing organization, may be combined with alcohol and drug services or it may be the county health department that provides those services.

And then it's good to know within your parish where are people with mental illness located, besides just in parish households, group homes or other residences in the parish in which people with mental illness reside.

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So with that, I am going to pass it over to Sister Sharon and she will start talking about her experiences working in the state hospital. So Sharon.

>> Thank you, Dr. Tom. I'm not supposed to call him that.
(Laughter)
The very thing you say don't do, you do. Anyway, thank you very much for introducing me. And I would like to say that it's a privilege to be here and to share what little bit of knowledge that I do have with you. And some of you may have already worked with people with a mental illness, and you have found that they can be very passionate in their religious ideations or religious belief, the way they practice their religion, whatever faith group they might belong to.

And for me often that is inspiring, because I see them in a situation where they have so many things going against them for actually practicing any kind of faith, and yet they hang onto it. It's a real support to them.

Now, their symptoms of mental illness may color what comes through to us. So when we look at that, we want to be aware that we need to look deeper at what is going on within them.

But, first, I'd like to go to the next section, patients in psychiatric hospitals. Okay. They might exhibit certain characteristics that we're all familiar with. They may attend the worship services offered on site.

Or, in some cases, when their illness is well controlled, they can get a pass to go out to a local church of their choosing sometimes they don't want to go to church at all. They may have various reasons for that. It may not be their pattern. They never did as a child but they are believers. And it could be that whatever they're doing in their faith it's very private to them. So they will read the bible and other religious material faithfully, and they often will talk freely to other patients regarding their faith, even if they get a little bit excited to the point of proselytizing, and we want to look at other aspects of how they practice their faith and encourage them to practice their faith without doing that proselytizing, because that can be a way to push people away from you. They do request religious symbols or articles from time to time. That's been important in their life. And it still is.

And we also want to look at other things that they might request. Such as a visit by a chaplain or a clergy member, especially at a time of loss or crisis. And they have in their background the knowledge that when they were in trouble, the church was the first place to go to. And they turned to the church or their particular faith group in order to get that same kind of support and help.

The people in the hospital do spend quiet time in prayer and contemplation, and that's important to them to have that space in a building that may be quite noisy. A lot of activity is going on. And to have that quiet time is important to them.

They often seek some kind of spiritual direction. Once in a while -- and that did happen to me at one point -- I thought a man was just seeking attention when he asked to see me. But when I actually started talking with him, I found that he did have

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some very serious questions about his spiritual life. And he wanted some support and help.

So we need to be patient with people and look beyond what they might exhibit normally to you such as attention-seeking. They may have some underlying issue that they really want to deal with. Then they also have a need for connecting with a faith community and they want to stay connected. And we provide for them a religious visitor and the hospital where I work tries to find a faith community in which they can relate once they leave the hospital.

Now, they also like to participate in a prayer service or a group that is discussing spiritual items. And so patients in a psychiatric hospital might practice their religion, talk about their faith, seek spiritual support, just like someone hospitalized for any other medical problem. Chaplains are often called upon to help people with problems in an acute care hospital, and the same need exists in the psychiatric one.

We want to be able to dig deeper and help people find that flame and identify it, that flame of faith and keep it going for them. Some people who are experiencing psychotic symptoms and even including religious delusions will tell us stories that seem really strange and odd. For instance, the person with whom I was talking at one point was talking about God in such a way that God knocked on my door and I invited God in and then I asked him to leave but he wouldn't go and the door slammed shut and God was there.

A family member at the same time was listening to this conversation and she told her brother, "now, would you say that in a different way?"

He said, okay, well, Jesus came into my life and I've been with Jesus ever since he's been with me. That is more common terminology. He was using a metaphor. So sometimes whatever we hear, it may sound to us like it's a very strange thing, but actually it can have an underlying basis in faith so we listen for that kernel of truth beyond the symptoms. Then we can ask about their own faith history. Tell me more about your faith. Where did you grow up? Like what church did you like to attend when you were younger? And sometimes the God-talk or the church-talk may not be familiar to us but it was common to that particular branch of faith that people were practicing.

And sometimes at a communion service we'll have people come and we'll be singing a song and I'll see people waving their arms, face directed toward the ceiling, eyes closed they're not going into any kind of psychotic episode at that point, they're doing what was common for them when they visited another church, which was more Pentecostal. So sometimes it's not a delusion, their talk or their actions. It comes from a different tradition. To explore that with them is very different. And then finding the flame. If we look at people who are recovering from psychotic symptoms, including religious delusions, we need to support their insight into what have been misperceptions. At work I was talking with someone who was afraid of being kidnapped by an important person in our United States. Not a political character at this point. But was very afraid because that person in his mind was evil. And

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underneath it then, at the end of the conversation, I said well what I hear you saying is that you are afraid of people that you consider evil. And he said, yes, that's it.

So at one point I could identify him but I was not necessarily supporting a delusion that this important person had kidnapped him. So finding the flame takes patience. It takes digging a little deeper, takes acknowledgment of the disappointment and frustration of the person when they finally understand that they're hearing voices and that they're not real. I've seen that take place in many people.

And then sharing scripture or other accounts of their healing, deliverance, conversion, is very important to hear them out and support them where you can.

Usually a visit often is ended with a person who has an illness or a delusion. And they will ask for a prayer before the chaplain leaves. And that's extremely important to them. It reminds them yes they're a person of faith, yes God is with them, yes, God is watching over them. Now, we do have prayer services, and I'll go through that very quickly, I think you can see that on your screen there. And basically I'll summarize and just say that the environment is very important to have it kind of soft and quiet for them. You can use scripture text or a text from some other tradition. If it's got a good moral point or something that relates to God for them.

And you can facilitate a discussion with them by asking what they were struck with in the passage. Then keep it within a context of half an hour, because time is hard for them. So in closing this, we just might recall that the prayer service can end with a song, begin with a song, something that reflects the theme.

If you have any questions, we'd be glad to entertain them at this point. But I'll turn it back over to Tom."

>> Thank you, Sister Sharon. Thank you for sharing that rich tradition and rich experience that you had working with people in a hospital that is not always the greatest place to be. Some of you may have seen in national coverage.

Well, at this point we'll shift to fielding some questions from you. So if you'd like to submit questions by clicking the Q&A button, we will try to address those as well as we can.

And actually here's one maybe I'll ask Sharon to answer this one regarding Eucharist. Do you -- I'm sorry. Do you commonly request or administer Eucharist, provide Eucharist to someone in the hospital, or do you test them or make sure that they actually understand what's going on or how do you determine whether someone receives Communion or not.

>> Sometimes the person will come and say “I'm not Catholic, can I receive communion?” I answer appropriately, usually that's not our practice. They're very respectful. In fact, one man who is Catholic asked, he said I've never made my first Communion. But I'd like to get ready for it. He was respectful about not going up to the table right away.

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The other part of that question, do I do some kind of screening? Sometimes people are new to the hospital. They just come in. They come to a Communion service, I remind them that they need to believe that this is the body of Christ and that if they don't believe that, we refrain from coming up to the table.

Most of the time Catholics who do come and they do receive, once in a while, now I have to be honest, once in a while there will be a patient or two that slips through and it could be that's exactly what they need from their own tradition.

For instance, the Protestant tradition that has commonunion. And because of their illness, they haven't been able to determine the difference between our services and that does happen once in a while.

>> Okay. Another question was about how do you respond to a family who can no longer care for a child with mental illness because of behavior, maybe they're too dangerous, not safe, but they can't get the person hospitalized and how do you minister to them? That's a very common unfortunate situation. A lot of that relates to the various laws regarding involuntary hospitalization, the shortness of hospitalizations currently.

I don't have a good, quick answer for that. Sometimes it helps to connect with someone in the community who is either an advocate, even I think some of your directors are good at knowing what is available if there are other resources maybe short of hospitalization, residential resources, that can be utilized. And I think during that process, the way to minister is to, again, be a friend, be a support, include that family in your prayers and in the life of the parish, depending on the comfort level of individual parishioners. Maybe supervise that individual, allow that parent some free time or even allow them to go to mass, if they are able to get to mass. So ministering the way you would to someone who has a serious illness.

Dorothy has something that she would like to add.

>> This question is very real for me because we have three families right now with a similar situation of children under the age of 10. The family has to lock the bedroom doors at night because it's not safe. And they've had difficulty finding resources to help their child or to have them hospitalized, just as your question asked.

I found myself praying for them, number one. Accompanying them, letting them know they're not alone during this difficult time, and then myself searching out resources, what are the resources out there for families, knowing they are so weary from their experience of this every day, that sometimes they're not aware of other resources.

And I've found now that there are three families with this same situation. One family has found resources, and the families have now become a support to each other. So even helping make the connection between families, for them not to feel alone in this has been very helpful. And I just continue to call and see how the family's doing, see if a resource that was suggested to them was helpful, and if not, we'll keep searching.

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>> Thanks. I just realized that I may have omitted one of my slides here. Let's see. Here we go. I think I may not have shown this. These are some, just a small example of resources that are helpful. One that I've referred to earlier is the National Aalliance on Mmental illness or NAMI, their Web site nami.org has links, most counties will have a local affiliate of NAMI, provide family to family training, 12 week training session for families with mental illness that's very helpful in increasing their knowledge of what mental illness is and their ability to deal with a family member with mental illness. Our Web site. And NAMI has a program called Visions For Tomorrow which is for family members who have small children with mental illness.

NAMI Faith Net is an interfaith resource as is Pathways to Promise. Pathways to Promise has great printed resources you can access including a brochure entitled when mental illness strikes in a Catholic family. It's very helpful to have a brochure rack in church. Mentalhealthchaplain.org, that is the organization that Craig Renenbaum directs out of Seattle and has a grant to provide companionship training and we'll actually be hosting him here in Portland in November.

Another question has to do with just whether our slides and the presentation will be available afterwards. And, yes. My understanding is that an archive of the webinar will be available through the NCPD Web site. So you can view it again or others can view it.

And let's see. Maybe I'll ask Sharon this. How do we respond to someone who sees stories of healing in the scriptures and then feels that they aren't being healed? Does that mean their faith is somehow less than it should be?

>> Oftentimes that does come up, and people are distraught by that. And to be able to be spend time with them and find out what's going on, it could be they're affected by deep depression at the time. And so it seems like they're abandoned and that God is not with them.

So it is complicated. And also that I often counsel them, if it's of their faith tradition, that this might be a time of learning and growing and that if we want healing immediately it doesn't always happen. That we can be in union with the suffering Christ who wanted to show us how to get through suffering himself. Spending time with them on passion of Christ and how they might be in union with that until the time comes when they get some relief and a complete healing sometimes is not meant for everyone but they still have gifts. And so it's important to point out the gifts that they do have that can help others by the way they are getting through their depression or whatever is troubling them.

>> Good. Thank you. We've got a couple of questions, kind of relating to how do you -- I think I could rephrase it as how do you set limits when parishionors who have mental illness or those who don't have mental illness get in the habit of calling incessantly, sending emails, lingering after mass not allowing the priest to leave, being very insistent.

And I think the approach is, again, being compassionate, being kind. But that there are limits that we all have and that it's okay to assert those. For someone who maybe

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makes multiple contacts, what I found helpful just in terms of my psychiatric practice is saying I really want to hear what you have to say, sounds like you have a lot of important things to say, but I can't focus on that very well when you call so many times. So how about if you will call once a day, or maybe once a week, or if you're in a situation of an e-mail, maybe you'll say I think I would be able to look at one e-mail every Tuesday and Thursday, because that's when I'm in my office.

And be sure -- take notes, save up your information, because if you send anything other than that, I'm just not going to be able to read it. But I will read that one e-mail on Tuesdays and Thursdays or I will direct the secretary to only connect your call when you call on Monday afternoon at 3:00.

So the person knows you're not shutting them out. You're not treating them wrong. But that you have limited resources and times if you're reading too many emails that might mean you'll miss someone else's e-mail that might be important as well. It's a compassionate yet firm way to say this is what you can and can't do. And hopefully the person will respond to that.

Let's see. Another question is -- let's see. Maybe more -- oh, yeah, more examples of someone who during a mass might be agitated or upset or disruptive. I think one way is to allow or to hopefully allow, it's hard to create a culture in which people accept movement or agitation within someone in a parish. It might mean that the ushers, the greeters are trained in how to approach someone and just ask them, are you okay? Would you like to sit here? Would you like to come here? They may have just a basic need. They may need to know where the restroom is, maybe as simple as pointing that out to them.

And being able to do that in the least attention-gathering way. So that's respectful and doesn't detract also from the rest of the mass.

I think one example I have is of a friend that I sponsored in RCIA, someone we had to do a modified process because of his symptoms, he couldn't participate in the classes because he was having so many hallucinations and delusions, that we did a separate process. He continues to come to mass, 10 years later, after being received into the church. But he paces a lot. And he feels self conscious. Even though I invite him into the sanctuary and the church he sits behind the glass in the back of the church, essentially the crying room so that he can pace and go to the bathroom. And so what I've done, instead of continuing to badger him about coming and joining me inside, when he's there I sit in the back with him. So the congregation moves to greet him.

What happens if someone is in crisis and shows up at the parish or rectory or parish office. It's important to know where the resources are in your community. If it's clear there's an emergency, they may be talking about suicide, that really takes emergency intervention and knowing whether 911 is the number to call if there's a crisis line that's a more appropriate call to make to hopefully get maybe more mental health trained professionals to respond.

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And also just knowing some basic safety things. Some people can come into a parish with or without mental illness who pose a threat. So feeling comfortable finding help from other people in the building maybe to provide support.

I want to save a moment to talk about suicide. This is a topic that I really can't do justice to and would really take a whole conversation about, but just remember that suicide has a huge impact on a family, if someone dies by suicide, it's very devastating to a family and to a parish and to a community.

But the reality is that serious mental illnesses do have a certain degree of mortality. And with these mental illnesses, sometimes that mortality comes through death by suicide. And that we really often can't prevent it, as much as we want to. Can't predict it and can't prevent it.

Let's see. For questions that we don't have time to answer, we can try to e-mail a response or maybe if you want to e-mail the NCPD main e-mail address with your question, Jan and Nancy can forward those on to us.

Let's see. We've got so many great questions here. I'm afraid we're not going to get to all of them. Let's see. We're just trying to -- I'm sorry. There we go. Okay. So a question about if someone has a delusional system and they believe that they're Christ how far should the family push to indicate that it's an illness? Especially if the person isn't taking medicine, doesn't want to accept that they're ill?

Very difficult. I see Sharon smiling. I know that she deals with that too. I think the way to talk about it is not acknowledging that you believe them but do not dismiss them as a person.

>> Yes, that's a problem, and we do have a number that believe that in our situation at the hospital.

>> And it may just mean talking to them as an individual and rarely people will demand the profession of faith from us as we talk to them about their assertion that they're Christ. So often we can just not acknowledge it, talk about whatever the issue is at hand, whether it's loneliness or frustration without actually addressing that.

Because we know that delusions by definition are so strongly held. A person isn't talked out of their delusions. We can't convince someone otherwise. So there really is no reason to try it. But we can say things like you know I don't know about that. My understanding is that maybe I don't think you are Jesus. But I bet that the spirit of Jesus lives in you. There are ways you can sort of finesse it. And that is respectful.

>> Getting to the kernel of what's underneath it all.

>> Right. I'll pass the phone to Dorothy now for some closing remarks.

>> We are concerned about the many questions that have been asked that time has not allowed us to answer. And so we will find a way. We do have your e-mail addresses, and possibly be able to e-mail an answer to you as well.

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We want to thank everyone for participating in this webinar, and in closing, appreciating the fact that this week is mental illness awareness week and yesterday was the day of prayer for people with mental illness, we would like to invite all of our participants to join us in prayer at this time.

Loving God, we entrust to your loving care all who live with mental illness and their families. And I would invite you to think of specific people in your parish who you're aware of at this time.

We pray for the church, for all of us gathered here, that we do grow in understanding so that we can offer the kind of supportive community that truly welcomes people that affirms their dignity and the kind of community that grows in relationships that provide the healing and hope so needed by people who live with mental illness and for their families. In faith, we pray with confidence in the name of Jesus, your son. Amen.

We need your help to improve future webcasts. We would be grateful if you would now participate in the completing the evaluation on your screen to consider each of the questions and offer any suggestions at the end that you might have to make this more effective. And when you are finished, if you would please click on your screen Submit Responses.

We want to remind those who have multiple participants, please have each participant go to the URL that is scrolled across the marquee offered on your screen and fill out your webinar or your evaluation after the webinar. And we would ask that these be completed and returned to NCPD by October 15th.

Once again, thank you all for joining us in this webinar on supporting people with mental illness in your parish.

>> Thank you.

>> Thank you.

>> Good-bye.

>> Good-bye.

THE MODERATOR: This concludes today's teleconference. You may disconnect your lines at this time. Thank you for your participation.