GUIDELINES FOR DEALING WITH MENTAL HEALTH ISSUES

The Presbyterian Church in Canada

2023

Guidelines for Dealing with Mental Health Issues

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OVERVIEW OF GUIDELINES

The church's essence as the body of Christ in the world shapes its approach to mental health issues. Responding to the gospel mandate to love, the church strives to promote good mental health and intervenes pastorally in particular cases.

Promoting Mental Health

The church promotes good mental health in ways appropriate to its nature and role. The church:

- prays
- develops communities of worship, learning and service to nurture spiritual growth
- fosters community where mental health issues can be disclosed openly
- partners with institutions in education about mental health, in advocacy, and in justice ministries
- nurtures healthy church courts
- provides benefits plans (for ministers)

Pastoral Intervention

The church intervenes pastorally by offering pastoral care, guidance and support, sometimes including referral to others.

The procedures for pastoral intervention are based on sound guiding principles:

- priority is given to the safety of all persons, respect for confidentiality and human rights, and timely self-referral
- open disclosure of mental health issues requires good understanding of mental health
- pastoral intervention is based on a request for help from the person of concern or observed behaviour of that person that raises concern
- pastoral intervention may be appropriate even when the person of concern does not acknowledge any difficulty
- the church courts have responsibility to care for individuals and groups under their jurisdiction, and to maintain the integrity of the church's witness
- due process precedes formal church court action affecting a person's reputation or employment
- the church is to use these guidelines with prayer, love, humility and reliance on the Holy Spirit

Two types of situations provide the context for pastoral intervention:

A − the person of concern asks for help
B − the observed behaviour of the person causes concern

A − When the person of concern asks for help, the church offers support:

- prayers
- caring, compassionate company
- respect for confidentiality
- assistance in finding the services of appropriate medical professionals
- for ministerial leaders, ensuring that the church's benefit plans are known and understood
- practical assistance
- pastoral care for the family of the person
- relief from church roles and responsibilities as necessary for recovery
- pastoral care and appropriate replacement leadership for the congregation, as necessary
- education of the church community about mental health issues

B − When the observed behaviour of the person causes concern, conversations begin:

- In a setting that protects the person's privacy, the observer asks the person about what they are experiencing. Both persons should have a companion present.
- The circle of individuals engaging in conversations with and about the person of concern widens to include the responsible church court.
- The involvement of the church court may lead eventually to a non-disciplinary case (Book of Forms 324–344).

INTRODUCTION

Good health is a gift that enhances life and makes even the steepest obstacles appear surmountable. Its absence yields the opposite effect and is keenly felt. Whenever poor health extends to the mental and psychological aspects of a person's being, the challenges are compounded by the stigma society frequently attaches to mental illness.

The church is no stranger to these realities. Because its members are human, they experience the whole spectrum of health. They bring to the church's life all of who they are – body, mind and spirit.

While the church is a community of human persons, its true nature is something quite different. In the words of Living Faith, "The church is Christ together with his people called both to worship and serve him in all of life."[1] The apostle Paul called the church the body of Christ, "the fullness of him who fills all in all" (Ephesians 1:22–23, NRSV).

One of the hallmarks of this divine-human community is love. Jesus commanded his disciples to love one another as he had loved them (John 13:34). The New Testament anticipates Christian love finding expression within Christ's body in a variety of "one another" ministries. We are to pray for one another, to carry one another's burdens and to admonish one another. In Christ we are as inter-dependent as the different parts of our human bodies: all rejoice when one rejoices and all suffer when one suffers (1 Corinthians 12:26). Living Faith offers us a description of the kind of community God intends us to be:

> The church is the family of God.
> Here all should be valued for themselves.
> We are one body in Christ:
> together rejoicing when things go well,
> supporting one another in sorrow,
> celebrating the goodness of God
> and the wonder of our redemption.
> (Living Faith, 8.2.6)

The gospel mandate to love one another has clear implications for the church whenever one of its people is experiencing mental health issues. We are to provide appropriate care for all who are involved – the individual, the individual's family, the individual's congregation – while at the same time maintaining the integrity of the church's witness to the wider community.

However, while the mandate to love is clear, the way forward is less so. What constitutes appropriate care? If the individual refuses professional help or rejects diagnosis or treatment, what can and should the church do? Mental health issues, if untreated, may become disabling for the individual. If untreated, they can also present challenges for the individual's family and congregation and for the wider church. Moreover, many of these conditions create challenges for the individual, and for the family and congregation, before the individual is willing and able to acknowledge experiencing a mental health issue. What can the church do to foster positive outcomes? The courts of the church have an obligation to act for the good of the body of Christ, while holding it accountable for its responsibilities, even as the

courts have an obligation to act for the good of individual members and hold them appropriately accountable. How does the church honour these obligations faithfully?

The Guidelines for Dealing with Mental Health Issues have been developed to give guidance to the church in addressing these questions. From the foundational understanding of the church as the body of Christ in the world, the policy discusses guiding principles and measures to promote good mental health. It then outlines procedures for church responses when a person asks for help with mental health issues they are experiencing or when the observable behaviour of the person indicates possible mental health issues. In cases when the person refuses the pastoral intervention of the appropriate church court, possible next steps are outlined.

NATURE AND SCOPE OF THE GUIDELINES

The guidelines are intended to provide guidance to the church as a caring community in relationship with individuals who may be dealing with mental health issues. They also strive to stimulate discussion and education within the church that will help foster healthy, affirming environments.

The term “mental health issues” is used to refer to a broad constellation of problems affecting mental, emotional and psychological health. These include but are not limited to mental disorders due to general medical conditions (e.g., certain types of dementia, stroke), personality disorders, psychotic disorders, mood disorders (e.g., anxiety, depression, bipolar), alcohol and other drug abuse or dependence, stress and burnout, and major anxiety disorders like posttraumatic stress disorder. It is important to distinguish between situational conditions affecting mental health (such as depression arising from grief) which may be of limited duration and ongoing conditions affecting mental health which may require long-term management.

It is imperative to note that the church’s role is never to offer a diagnosis. That task remains the purview of qualified health care professionals. For this reason, the church avoids all use of diagnostic language. In a similar way, the church does not attempt to offer professional support itself, but rather directs the person to a health care professional when needed. The church understands that its proper role is to offer pastoral care, guidance and support.

The guidelines describe some of the forms that pastoral intervention by an individual, group or court within the church might take. Such intervention is initiated in two different ways. An individual, referred to as the “person of concern,” asks for help with challenges they are experiencing. Alternatively, the person’s behaviour is observed by others who become concerned that the person may be experiencing a mental health issue. While the impetus for the development of these guidelines was a concern for the leaders of the church, both clergy and lay, they could be used in dealing with any member of The Presbyterian Church in Canada who might be experiencing a mental health issue.

GUIDING PRINCIPLES

Timely self-referral is a central goal of the church’s initiatives concerning mental health issues. As with other health matters, early assessment and intervention by a mental health professional are more likely to lead to optimum outcomes.

A good understanding of mental health is essential to creating a climate where mental health issues can be disclosed without fear of criticism, ostracism, or reprisals.

Human rights of individuals are respected and discrimination of any kind is unacceptable. In relationships where the church is an employer, it takes care to protect employees and prospective employees from discrimination based on disability, including mental disorders.

The safety of all persons is a priority. Circumstances may in some instances warrant police intervention or legal remedies such as a restraining order. Where the safety of minors is a concern there is a legal duty to report to the appropriate child protection agency. Where the person of concern displays intent to place themselves or others in danger, there is a responsibility to take reasonable action to prevent self-harm and to warn threatened individuals.

Confidentiality is respected as much as possible within the limits of the law. Confidentiality cannot be kept where harm to self or others is likely, or where minors are endangered.

The basis for pastoral intervention is either a request for help from the person of concern or observed behaviour of that person that raises reasonable concern about the possible existence of a mental health issue.

Pastoral intervention may be appropriate even when the person of concern does not acknowledge experiencing any difficulty.

The courts of the church have responsibility to care for the well-being of the individuals, congregations and other groups under their jurisdiction, and to maintain the integrity of the church's witness.

Before formal action affecting the reputation or employment of a church leader is taken, the due process of the church court will be followed.

The church is called to implement this policy in the spirit of prayerfulness, love, affection and humility, under the continual illumination of the Holy Spirit.

PROMOTING GOOD MENTAL HEALTH

The church's primary task is to be who Christ has called it to be – the embodiment of Christ's presence in the world by the power of God's Holy Spirit. This means living in ways so that all who are touched by the church may experience the transforming grace and love of God.

When it comes to mental health, the church longs for people to be whole, to get the treatment they need, to experience healing, and to recover their place in society and in the community of faith as fully as possible. The church's desire is to offer appropriate support.

The church offers support through intercessory prayer for others. The church also prays for itself, recognizing that it needs the promised guidance of the Holy Spirit to be conformed to the mind of Christ and to see others as he does, longing for them to know the healing, restorative power of the love of God.

The church offers support by offering a worshipping, learning, serving community where spiritual growth can be nurtured. Spiritual life is an essential and necessary part of good mental health.

The church offers support by fostering a community where mental health issues can be disclosed in a spirit of openness. In doing so, the church resists the prevalent stigma against mental illness. Instead, it allows its beliefs and behaviour to be formed by biblical principles, such as the gospel mandate to love, and to be informed by the best available scientific research. The Canadian Mental Health Association teaches that recovery from mental illness is possible.[2] With treatment, in many instances individuals can resume a good quality of life. People living with mental illness on a daily basis can achieve good mental health – striking a balance in the spiritual, social, physical, economic and mental aspects of their lives.

The church offers support by partnering with other institutions whose primary task is education about mental health; or advocacy; or justice ministries addressing the needs of individuals or related underlying issues (such as poverty). For instance, in its desire to educate its people about mental health issues, the church invites qualified people to lead seminars and retreats for the congregation, session or presbytery. One important educational goal is equipping church courts and leaders to make good referrals.

The church offers support by nurturing healthy church courts. Sessions, presbyteries and synods that understand and accept their roles, and whose members know and care about one another and share a commitment to their work – these are least likely to contribute to a leader's burnout track and most likely to recognize early the mental health issues of one of their number. They are also best equipped to guide the individuals, congregations, and other groups under their care when mental health issues require difficult decisions.

The church encourages covenant groups that may help ministers seeking such support.[3]

PROCEDURES FOR PASTORAL INTERVENTION

Pastoral intervention by the church takes the form of pastoral care, guidance and support, which at times may include referral to others.

Two types of situations provide the context for a pastoral intervention:

A − the person of concern asks for help.
B − the observed behaviour of the person causes concern.

A − The Person of Concern Asks for Help

A person in the church acknowledges to an individual, group or court within the church that he or she is experiencing a mental health issue. The church responds by providing support in ways that might include the following:

- Prayers for healing, strength and confidence in the abiding presence of God.
- Caring, compassionate company on the journey.
- Respect for confidentiality.
- Assistance in finding the services of provincially credentialed or licensed medical or mental health professionals.
- For professional church leaders, ensuring that the church's benefit plans are known and understood, including financial assistance with the costs of pulpit supply for congregations whose minister is on a health leave.
- Practical assistance (which may include financial) with accessing health care, travelling to appointments, and managing financial and other affairs.
- Pastoral care for the family of the person, including assistance with the relationships between the family members and the person, as requested and as appropriate.
- Relief from church roles and responsibilities as necessary for recovery.
- Pastoral care and appropriate temporary leadership for the congregation, as necessary.
- Education of the church community about mental health issues to foster acceptance and welcome rather than criticism and ostracism.

B − The Observed Behaviour of the Person Causes Concern

1. A person in the church becomes concerned that the observed behaviour of another indicates the possible existence of a mental health issue. The observer may be a family member, a member of the congregation or a ministry colleague. In a setting that protects

the privacy of the other, the observer gently asks the person of concern about what they are experiencing. The observer should have a companion present for this conversation. The person of concern should also be encouraged to have a companion present for any consultations. A qualified mental health professional must be consulted in advance for guidance before any intervention is made.

A word about meeting privately:

The Presbyterian Church in Canada takes seriously the process for reconciliation that Jesus teaches (Matthew 18:15–18). This process involves first dealing directly and privately with the other person, one-to-one, and then as the process continues, keeping the circle of involvement as small as possible until enlarging it at the next step becomes necessary. Following these instructions, the Book of Forms requires members to attempt to resolve their differences before they ask the church courts to help through judicial process (sections 314, 314.1, 325, 328.1, 350).

Jesus' teaching provides the framework for healthy communication within the church generally across a broad range of contexts and not just when reconciliation is needed. Nevertheless, an exception to the "meet privately first" rule is warranted when dealing with possible mental health issues. The wisest course is for the observer to have a companion present when approaching the person of concern.

2. If the person of concern does not acknowledge experiencing a mental health issue and the observers remain concerned that there are problems, the observers consult with the moderator and clerk of the church court responsible for the person of concern.

   References to the "responsible church court" in this document denote the church body that is responsible pastorally for the person of concern and to which the person of concern is accountable. Except for certain employment contexts as noted below, the "responsible church court" is the session, for lay employees, members or adherents of the congregation; and the presbytery, for ordained or diaconal ministers or certified candidates for ministry or ordination.

   The church employment contexts that give rise to exceptions to this general rule are as follows:

   - Employees of the synod are accountable for their employment to the synod.
   - Employees of the colleges or other institutions of The Presbyterian Church in Canada are accountable for their employment to the governing board of the college or institution.
   - Employees of the national Presbyterian church offices are accountable for their employment to the Assembly Council.

3. This initial inquiry and consultation will lead to one of the following courses of action:

   - No further action is taken.
   - There is another meeting with the person of concern.
   - The observers consult with an appropriate medical or mental health professional to discuss the next steps which should be taken.

   In these consultations, it is important not to libel, nor to appear to libel, the person of concern, for example by using diagnostic labels. Instead, the focus is on the observed behaviour, the possible issues of mental health that such behaviour might indicate, and the need to have a professional assessment to determine the cause.

In consultations with a health professional, the name of the person of concern is not made known. The observers seek enough appropriate information to help clarify which option to choose.

Persons who take the role of observers in these situations are enjoined to do so prayerfully, pastorally, and with humility – and in a way that ensures that they are not acting out of personal bias.

4. These consultations may yield one of the following outcomes:

   - No further action is taken by the observers.
   - The person of concern seeks professional assessment and, if indicated, treatment, and communicates this fact to the responsible church court or gives others permission to do so. The court ensures that the church provides appropriate support, by such means as are listed above.
   - The behaviour is observed to continue and the person of concern does not seek professional assessment and, if indicated, treatment. The observers have the following options open to them:
     - If there is immediate danger to the person of concern or to others, the police service is called so that the person of concern might be conveyed to an appropriate facility for assessment and treatment.
     - The observers communicate their concern in writing to the responsible church court.

5. Responsibility for pastoral intervention rests with the responsible church court once the matter has been referred to it in writing. The responsible church court must call a special meeting (sooner than their next regular meeting, Book of Forms 5.1) to facilitate an expeditious response. The responsible church court has the following options:

   - The court, perhaps inviting further involvement of the observers, names individuals to meet with the person of concern, with a view to encouraging the person of concern to seek professional assessment, and, if indicated, treatment.
   - If the person of concern seeks professional assessment and, if indicated, treatment, and communicates this fact to the responsible church court or gives others permission to do so, the court ensures that the church provides appropriate support, by such means as are listed above.
   - If the person of concern does not seek professional assessment, and if indicated, treatment, or when further encouragement to do so is not expected to be effective, the court begins judicial process, using the appropriate established procedures of the church to initiate a non-disciplinary case (Book of Forms 324–344). In engaging in judicial process, the court must adhere to the principle that due process precedes any decision of a court affecting the employment of a church leader.

6. A decision to begin judicial process is directed towards the following goals:

   - To enable the responsible church court to ascertain for itself whether the person's observed behaviour merits further concern.
   - On deciding that the person's observed behaviour merits further concern, to facilitate the court using its influence appropriately to help the person of concern to obtain the professional assistance needed.
   - To follow the church's established procedures fairly – a standard that will serve also to inspire confidence in the results.
   - To safeguard the wellbeing of the person of concern and the people within their sphere of influence.
   - To safeguard the integrity of the church's witness.

In engaging in judicial process, the court recognizes that experiencing mental health issues is not a sign of moral weakness. Moreover, denial is often an integral part of mental health issues, rather than a wrongdoing for which discipline is required.

7. When the decision has been made to begin judicial process, the responsible court follows the procedures for non-disciplinary cases that apply to the particular person of concern. This commences with the laying of a complaint – Book of Forms section 325, in the case of those accountable to the session, and section 329 for those accountable to a presbytery. The church's procedures for judicial process might serve as a helpful resource for other church bodies (e.g., synods, college governing boards, Assembly Council) as they seek to fulfill their responsibility as employer to act appropriately.

   The laying of a complaint in this situation must be carefully undertaken as a pastoral act seeking the welfare of the person of concern and the church they serve.

   - For ordained or diaconal ministers employed within the church and not serving in one of the exceptional employment contexts noted in section 2 above, the presbytery conducts an investigation, which may be followed by a review of ministry (Book of Forms sections 334–340).
   - For ordained or diaconal ministers not employed within the church and for certified candidates for ministry or for ordination, the presbytery conducts an investigation (Book of Forms sections 334–335).
   - For individuals under the care of the session and not serving in one of the exceptional employment contexts noted in section 2 above, the session follows the procedures for complaints against members and office-bearers of the church (Book of Forms sections 325–327).

   One possible outcome of such judicial process is that the responsible church court imposes a requirement of professional assessment, and, if indicated, treatment as a condition of continuance in office. Failure to comply may lead to suspension of the person of concern, either with or without a limit of time.

   A word about confidentiality:

   Church courts are advised of the need to respect the confidentiality of the person of concern, particularly about a diagnosis. The details of a diagnosis are not shared with the church court without the informed written consent of the person of concern.

8. Following any decisions of the responsible court, it decides what part of its proceedings will appear in the public record and carries out communication with others as necessary.

CONCLUSION

The church's essence as the body of Christ in the world shapes its approach to mental health issues. Responding to the gospel mandate to love, the church strives to promote good mental health and intervenes pastorally in particular cases.

APPENDIX A – EMPLOYMENT

The goal of treating people with love and respect is anything but new to the church. The gospel mandate to love as a free and grateful response to the love of God in Christ informs the church's understanding of its place in the world. The church tries to live in ways that enable others to experience God's love in all its gracious, transforming fullness.

While the church in every age has affirmed the goal of treating others with love and respect, it must be acknowledged that the church's concept of loving, respectful behaviour has changed over time. Perhaps the most striking examples are the New Testament admonitions exhorting slaves to obedience and masters to fairness (Ephesians 5:22–6:9, Colossians 3:18 – 4:1). Such instructions for life in community would be unequivocally rejected today. Time and place are key elements of the context that shapes people's expectations of behaviour.

In Canada in recent years, concern to safeguard the interests of individuals has led to rules prohibiting discrimination in a number of social areas, including employment. Each of the human rights codes (provincial, territorial and federal) identify the grounds that are protected against discrimination. Disability is one of the protected grounds common to all codes. Significant for this discussion is the fact that, in every case, disability is understood to include mental disorders. As a result, discrimination based on mental disorders is prohibited in the protected areas.

Employment Search and Selection

The legislated protections against discrimination hold implications for employment search and selection procedures. Employers are expected to evaluate the suitability of the different candidates based on the position's essential duties and bona fide requirements. Therefore, seeking information that falls outside this scope is not appropriate. Employers are not permitted to ask questions, either directly or indirectly, about the applicant's race, colour, sex, age, marital status, disability, or any other prohibited ground.

The same limitations apply to employer communication with the confidential references named by the applicant. References may be asked for information pertinent to job performance. However, it is unlawful to ask references a question that would reveal characteristics about the applicant that are protected against discrimination.

So, what importance does Canadian human rights legislation have for the church? The church seeks to offer the world Christ's gifts of grace, truth, wisdom, justice and compassion. Living as a good citizen, respecting and upholding the law, and being seen to be doing so – these actions strengthen the church's witness. Conversely, the world refuses to listen whenever it observes the church contravening the law. At the same time, the church wastes resources intended for mission and ministry in judicial process, whether inside the church or in the secular courts. These dynamics motivate the church to strive to uphold Canadian human rights legislation in all its activities. Human rights legislation which supports the good, ethical, and just treatment of human beings who are made in God's image offers a concrete way for loving our neighbour.

With respect to communication with confidential references in search and call procedures, what can a church ask about the minister's health? The answer is simple: nothing. The employer is required by law to protect the applicant's human rights and to focus exclusively on the requirements of the position. These stipulations prohibit discussion of any aspect of the applicant's health. Employers should not ask for such information, and for their part, references should not offer it. The implications of human rights legislation for the use of references are simple and straightforward.

Other Employment Matters

Canadian human rights legislation requires employers to adjust rules, policies or practices to permit employment of individuals with needs related to the grounds of discrimination. Employers have a "duty to accommodate," which means treating an individual differently to prevent or reduce discrimination.

Sometimes employees choose to disclose mental health issues to their employer (after hiring) and request accommodation in handling their condition. For instance, an employee could request a different work schedule, when changing the timing of the tasks enhances the employee's success in completing them. Typically, requests for accommodation of disability would be supported by correspondence from the employee's doctor. While there may be differences in these expectations across Canada, since some provinces and territories have enacted legislation in addition to federal laws, what should be noted is that Canadian employers have a duty to provide reasonable accommodation of disability to a significant extent.

APPENDIX B – CANDIDACY PROCESS

The candidacy process provides the framework for the vocational preparation and shared discernment by which lay members of The Presbyterian Church in Canada become ordained ministers of Word and Sacraments or designated members of the Order of Diaconal Ministry. Over several years, the individual listens for God's voice – the inner dimension of the call – while the church listens as well, testing the call's outer dimension. Unique roles are assigned to different groups in the church – the session of the candidate's congregation, the certifying presbytery, the theological college, and the congregation selected for supervised theological field education. Each one plays its part in engaging the individuals in discernment of their calling and in guiding their preparation for it. What begins with an individual nurtured in Christian faith within a home congregation may culminate in a presbytery confirming Christ's call through ordination to the ministry of Word and Sacraments or designation to the Order of Diaconal Ministry.

The church has been asked to give guidance to those engaged in the candidacy process when a candidate experiences a mental health issue. What are the implications for the candidate and how should those with roles in the shared vocational discernment respond?

The principle to be affirmed, first and foremost, is that having a mental health issue should not be viewed as a problem. Many ministers manage health issues and various kinds of disabilities, including mental health disorders, while continuing to provide vibrant, fruitful ministry. Some with mental health issues have chosen to disclose these to their congregations and presbyteries, thereby allowing those around the minister to provide care and support. Self-disclosure of this nature has also been a gift to those communities, since it holds the potential to combat the stigma surrounding mental health. Breaking the silence is a critical step to promoting good mental health.

When a candidate discloses a mental health issue, the church entity receiving the information should invite the candidate to indicate what accommodation, if any, is needed for the candidate to continue in the process. In some cases, the candidate might not need any assistance – with their current treatment and wellness strategies, they are enjoying good health and strength. In other cases, the candidate might need time to pursue medical treatment, and for this purpose, might ask the presbytery for an extension of time before the next recertification interviews. In a similar way, the candidate might ask the college for an extension of time to complete coursework.

The situation is more challenging when a candidate does not disclose a mental health issue, but others who have been observing the candidate's behaviour are concerned that one might exist. The church entity that is notified of such concerns (or that is, itself, the observer) would follow the pastoral intervention guidelines.

In all cases, the church entity receiving information about a candidate's mental health issues should respect the candidacy privacy within the limits of the law. Care should be taken to comply with the candidate's wishes when deciding what details can be released and in what context.

Within the limits of agreed-upon accommodation of disability, the church entity receiving the candidate's disclosure of a mental health issue should continue its role in assessing the candidate's suitability for ministry in The Presbyterian Church in Canada. While special provisions by way of accommodation might be in place, the church's responsibility to assess the outer dimension of the candidate's call to ministry remains unchanged. The same gifts and graces for ministry must be demonstrated by all candidates seeking to complete the church's candidacy process.

APPENDIX C – SELECTIONS FROM COMFORT MY PEOPLE: A POLICY STATEMENT ON SERIOUS MENTAL ILLNESS (2008)

The 218th General Assembly of the Presbyterian Church (U.S.A.) approved a major document on mental illness to be used as a resource in the church. Special thanks to the Presbyterian Church (U.S.A.), a Corporation, for kindly granting permission to use and adapt portions of its document, Comfort My People: A Policy Statement on Serious Mental Illness (2008).[4]

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Jesus' Ministry of Healing

In Jesus' earthly ministry he healed many people. Through Jesus' healing power the blind could see, and the lame could walk, "and they brought to him all the sick, those who were afflicted with various diseases and pains, demoniacs, epileptics, and paralytics, and he cured them" (Matthew 4:24 NRSV). Many of the people Jesus healed were not just physical cures, but they included restoring a person to ritual cleanliness and therefore full participation in community life (lepers). Some also included a healing of the soul through the gift of forgiveness (the paralytic). Still others included the gift of peace, shalom, and wholeness (the woman with the flow of blood).

In Scripture, it is clear that healing is not confined to physical cure. Therefore, we make a distinction between healing and cure. Cure refers to the elimination of a disease or a disorder. Healing, on the other hand, is something much broader, and may or may not include the elimination of disease or disorder. Healing includes reconciliation, restoration to right relationship, the gift of courage to live faithfully within limitations, internal peace, God's call to vocation, and living a life of prayer, mutually up building interpersonal relationships, committed church life, and self-giving service to the world. People can be healed even when they continue to live with a disease or disorder. Some have discovered that the relentless search for a cure for their disorder is a great burden, and therefore the appropriate hope is for healing, not cure. The challenge for the church is to be an instrument of healing when cure is not likely.

As sovereign over all, God is free to use any means to heal the sick. We may experience God's healing power through healing prayer, laying on of hands, anointing with oil, and the prayers of the church. We may experience God's healing power through participation in the love, nurture, and admonition of the church. We may experience God's healing power through medication and psychotherapy. As spiritual, social, and biological beings, God may extend healing power to us through all three of these means, as well as through surprising, wholly unexpected means. (p. 15)

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Definitions

1. **Mental Illness** is a medical disorder characterized by disturbance in thought, mood, or behaviour that causes distress or impairment of spiritual, interpersonal, behavioural and emotional functioning. If left untreated, all mental illnesses are impairing.

2. **Serious Mental Illnesses** are severe and persistent medical disorders characterized by impairment in mood or behaviour that cause distress and/or impairment in spiritual, interpersonal, and behavioural functioning. Salient examples are the disorders known as schizophrenia, bipolar disorder, and major depression. Characteristic symptoms of serious mental illness include hallucinations, delusions, disorganized thinking, extreme mood changes, overwhelming hopelessness and sadness, severely impaired perception, judgment, or insight, and problems with concentration and attention. Serious mental

> illness is an enduring condition that affects one's ability to cope with everyday challenges. If left untreated all mental illnesses may impair one's ability to establish and maintain interpersonal relationships, practice one's faith, worship God, attend school, go to work, or live independently. All mental illnesses can be impairing. (p.15-16)

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The Church Speaks On Serious Mental Illness

As our church considers issues of serious mental illness, we do so as a people moved by the suffering of many who live with serious mental illness; and many questions of faith arise from this consideration. Perhaps first and foremost is the question of how a good and powerful God can allow such pain. Is not it contrary to the very nature of the God we know in Jesus Christ? To witness the pain among many individuals and families affected by serious mental illness is to press to the limit our faith in God's love and power.

We cannot discern why there is suffering in God's good and lovely creation. We do know, however, that we are created as one body in the image of God, in our shared fragility, shared sin, our need to share God's grace in Jesus Christ, and our call to proclaim God's Reign. Therefore, as a church we are called to turn from our sinful ways, to turn from our pattern of exclusion, and to embrace all who live with serious mental illness as siblings, as co-members of Christ's body endowed with gifts for the upbuilding of the church.

While the church cannot eliminate a person's mental illness, we can welcome people who struggle daily with mental illness and thereby help reduce their suffering by changing chaos into wholeness. The church can recognize that although we might be powerless over some aspects of mental illness, God is not. Through the extraordinary power to love, we can share the precious gift of belonging with persons who have often heard that they do not belong. We can carry the message that by their baptism they bear the indelible mark of belonging to God's family forever. We have the opportunity to participate in the administration of God's grace to those recovering from mental illness, to their families and to covenant communities. (p. 16)

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Varied Responses to People with Serious Mental Illness

Mental illness has been present in every culture and age; and life in exile from community has been the fate of millions of God's children who live with mental illness. At times they have been the victims of unspeakable cruelty. People with mental illness have been burned at the stake as witches, lobotomized, subjected to painful medical experiments, confined in prisons, tortured, and executed. Yet at other times people with mental illness have remained a part of the community, living at home within families where their symptoms were accepted. Responses to people with mental illness have varied widely, ranging from forbearance and kindness to abandonment and exile.

Some interpret Jesus' casting out demons to be healing mental illness, and some also understand mental illness today as a form of demon possession. It is true that mental illness can cause great suffering for those who live with it and for their families—a suffering so great that it seems that something very evil must be causing it. We know from the New Testament gospels many reports that Jesus "cast out demons." The personification of evil that is found in those accounts seems to refer to real influences that bring chaos into human life. For example, in the fifth chapter of the Gospel of Mark, Jesus is confronted by "a man out of the tombs with an unclean spirit" (Mark 5:2, NRSV). The man's life is full of disruptive chaos in his inner experience and his outward behaviour. With divine power and authority, says the gospel, Jesus freed the man from disordering influences, restoring him to balance,

self-control, and appropriate behaviour in his community. “And he went away and began to proclaim in the Decapolis how much Jesus had done for him; and everyone was amazed” (Mark 5:20, NRSV).

Whatever may be the ultimate nature of the disordering influence in this account (which remains to some degree mysterious to us), there seem to be very few instances in our modern experience of such miraculous deliverance. The Church today seems called to employ far less dramatic and more clinical means to assist those afflicted with serious mental disorders to gain some measure of healthy order, balance, self control, and appropriate behaviour. Our role in healing and treatment follows the counsel of the Apostle Paul in Philippians 4:8, NRSV: “… whatever is true, whatever is honorable, whatever is just, whatever is pure, whatever is pleasing, whatever is commendable, if there is any excellence and if there is anything worthy of praise, think about these things.” In that light, we turn both to the truth, honor, excellence, etc., of modern medical science and to the love and grace of our Lord Jesus Christ as they are embodied in the life and worship of the Church.

We recognize that schizophrenia, bipolar disorder, and major depression must be addressed medically. We also recognize the Church’s responsibility to welcome and care for those afflicted with these disorders and to employ the rich means of grace that are essential to the Church’s life to aid in their healing and restoration. We believe that it is therefore not useful or appropriate to attribute serious mental illness to “the work of demons,” though we recognize that there are powerful disordering forces at work in all of human life – many of which do not appear at all demonic but which do bring chaos with them.

As serious mental illness came to be treated more constructively and compassionately, a more general acceptance of counseling and psychotherapy developed in society. The Church contributed significantly to this process through the work of hospital chaplains, leading to the development of clinical pastoral education, and through the pastoral counseling movement. These innovations added new dimensions to the traditional pastoral “cure of souls” and can be counted among the twentieth century achievements of the ministry and witness of the “mainline” church. (p. 18)

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Like the people of Israel in exile, many people with mental illness remain outsiders, excluded from the warmth of family, friends, and even the church. People with serious mental illness are excluded for many reasons. Some people believe that all people with mental illness are dangerous and violent, or fear that their illness might be contagious; others just fear their unconventional or inappropriate behaviour. Our churches should educate their members about serious mental illness and build understanding among all the members of Christ’s body. We recognize God’s call to proclaim comfort to people in exile by welcoming them home into the covenantal community of the church. If the church answers this call faithfully, the rest of God’s church shall find its way out of exile too: our exile from the possibility of becoming the loving community which God calls us to be. (p. 19)

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Discrimination and Barriers

As a nation and as a church, we confess our failure to provide adequate care for people with serious mental illness with devastating consequences. Our neglect has contributed to homelessness, addition, imprisonment, and for many, suicide. (adapted from p. 20) Even where people with serious mental illness do not face such overt problems, yet solely on account of their illness they struggle with society’s sometimes subtle but nevertheless destructive attitudes toward persons with a serious mental illness. The stigma of having a serious mental illness may deprive them of employment or adequate health care; or they may face the possibility of inappropriate involuntary commitment. (adapted from p. 20)

Stigma

When a person is physically ill, it is expected that they will be supported and treated sympathetically in their quest for healing. When one has a long-standing, disabling illness or injury, it is expected that they will be given every assistance and consideration as they cope with their limitations and any ensuing hardships. Not so with mental illness. Not only must those who are diagnosed with a serious mental illness cope with the illness as such, but they, and their families, must also shoulder the additional burden of the nearly overwhelming presence of stigma.

Stigma is a mark of shame, disgrace, or disapproval; it is a sign that one is different from others and should be rejected because of that difference. "Stigmata" were literally cut or burned onto the bodies of "different" individuals in ancient Greece and they were shunned. Today stigma takes the form of negative, inaccurate stereotypes, ostracism, and cruel, ignorant humor. Stigma prevents ill persons from seeking treatment in a timely fashion. It diminishes public support for funding of necessary and appropriate services for the mentally ill. It prevents persons who are in recovery from finding meaningful and secure employment and acceptable housing. Stigma contributes to cruelty in our criminal justice system. It precludes persons with mental illness from seeking and receiving the gift of community and, most importantly, it denies to those who live with mental illness God's gift of hope. Although its effect is much the same for the members of all groups, stigma can be particularly harmful to some racial/ethnics and immigrants with a mental illness because of the already existing burden of discrimination they bear. (p. 20)

To begin to redress the consequences of stigma one must recognize that its roots are to be found in our own fears. If we recognize that a person with mental illness is the same as any other person in every regard except that they have a particular illness, then we must recognize that we too could be subject to such an illness. (p. 21)

Barriers to Health Care

Various obstacles prevent people with mental illness from getting the medical help they need. Individuals with severe mental illness can be unwelcome in medical offices because they appear disheveled, have poor hygiene, and display idiosyncratic mannerisms. Their mood and thinking disturbances may elicit negative reactions. As a consequence they may receive only a cursory examination. Also, mental illness can create distortions in physical sensation, pain perception, and accurate reporting. A clear and complete history, without corroborating information obtained from others, such as a family member or friend, is difficult to obtain. (p. 25)

Some people may be denied appropriate physical care because of a prior diagnosis of mental illness. The medical staff might focus on the mental illness to the exclusion of the physical ailment. The primary diagnosis may become the only diagnosis.

Some people with mental illness choose to avoid medical treatment altogether because of a general fear of others, especially medical personnel who are perceived as untrustworthy. Simple things such as making appointments, observing waiting room protocol, filling out forms, compliance with treatment recommendations, getting prescriptions filled, and seeing specialists can be overwhelming. (p. 26)

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Impact on Families

The diagnosis of serious mental illness not only changes the life of the person who is affected, but also the lives of all those who surround him or her. Not only individuals with serious mental illness experience exile, but their families as well. (p. 32)

Many persons who are living with mental illness, and their families who live among us and are part of our congregations, receive little or no attention at all. This neglect may result from a lack of knowledge about mental illness within many churches and an unwillingness to become involved in complex and painful situations. It also results from the reluctance of families, because of the severe stigma attached to mental illness, to admit that a family member has a mental illness. (adapted from p. 32–33)

This forced silence, this inability to share and to talk openly about the illness of a loved one, compounds an abundance of other difficult circumstances and painful emotions. Having an ill family member—a child, a spouse, a sibling, a parent—is sometimes overwhelmingly painful and all-consuming regardless of whether the family member is in the home, living independently, in a hospital, living in community mental health accommodations or homeless.

For example, unlike parents who have a child diagnosed with a physical illness, those whose offspring have a mental illness are often overcome with guilt. For too long society placed responsibility for mental illness on parents and their ability to nurture. And even though these theories of poor parenting have been debunked, the stigma persists and adds a sense of blame and shame for parents to shoulder. Therefore, we must continue to work to eliminate the stigma associated with mental illness while at the same time also acknowledging that all forms of child abuse and neglect do affect the development of a child physically, mentally, and spiritually. We cannot condone any form of child abuse or neglect, especially parental child abuse or neglect.

Moreover, having a child, a spouse, a sibling, or a parent with a serious mental illness is similar to experiencing the death of that person, because in so many significant ways the illness takes away the person one has known. That person is gone along with the dreams and aspirations for them. However, the person has not died, and grief lingers. For months, sometimes for years, families have to endure this grief, often without the love, understanding and support from others. Frequently, the grief is accompanied by a sense of rage and anger. Mental illness seems particularly random in nature; all of its causes are not fully understood; and therefore, any understanding as to why it has happened to a member of one's own family is especially elusive. This combination of profound sadness and anger is a potent emotion, and can be crippling.

There is also a tremendous toll exacted on the entire family by the time and energy spent attempting to care for the person living with serious mental illness. This care requires working with an extremely complex mental health care system that few know about before it is needed, usually under conditions of crisis. (p. 33)

Frequently, the ill person requires round-the-clock supervision and assistance with medications and accompanying side-effects, constant vigilance to recognize signs of impending problems and crises; and if the potential for violence is present, particularly careful vigilance. Nearly unbearable levels of stress can burden the family members of the person with mental illness. One can reasonably say that having a person with mental illness in one's family and home can be totally consuming, leaving little if any time for the needs of any and all other family members. This demand on time and energy, coupled with the unpredictable course of the illness and the constant presence of stigma, make "normal" life—friends, social occasions, the activities of other family members, community concerns, congregational life—very difficult. These sacrifices are particularly burdensome to children and young adults who are sometimes required to be caregivers for parents with serious mental illness. (p. 33)

A mentally ill person's awareness of the impact of his or her illness on family members must not go unnoted. A person suffering from mental illness often acknowledges the adverse effects of the effect of his or her illness on parents, partners, siblings and, in some cases, an offspring. Their sense of responsibility for the perceived damage their illness does to the family increases the burden of the illness and further complicates the recovery process. Consequently, caring for the families of those with mental illness and helping to relieve their burdens not only strengthens them, but also helps to bring healing to the family member who is ill. (p. 34)

Violence

Perhaps the most damaging myth about people with serious mental illness is that they are dangerous, that their behaviour can turn violent at any moment. Perhaps this widespread belief is chiefly responsible for their being exiled from the covenant community. Many people come to church seeking safety and comfort, and the presence of someone with a serious mental illness may threaten their sense of security. [Yet according to Dr. Sandy Simpson, Chief of Forensic Psychiatry at CAMH, "Public fear around people with mental illness greatly exceeds the actual risk of violence they pose. In fact, studies show only a small proportion of violent crimes are committed by people with a serious mental illness. Only about four per cent of homicides are committed by people with serious mental illness. People with mental illness are more likely to be victims of violence than perpetrators of violence."[5]]

It is true that some persons suffering an acute episode of psychosis sometimes do become violent. In such cases churches are responsible for protecting those who might be vulnerable. Family members are at greatest risk for violence at the hand of someone with a serious mental illness. Since the potential for violence may exist, it is important that churches develop and implement a plan for maintaining a safe environment. For congregations who are called to reach out to people whose psychotic symptoms may lead them to acts of violence, mental health professionals can provide advice for churches that wish to create times and places where the possibility of violence is minimized. These churches can have safety plans in place should they be needed. (p. 36)

How should Christians balance the moral duty to take some risks to help persons with mental illness over against the obligation to protect others whom they might harm? Sometimes moral responsibility requires choosing not between a good thing and a bad thing, but between two goods that are in tension, as in this instance. How were the church leaders to balance the good of fully including persons with serious mental illness within the congregation over against the other good of protecting congregation members from possible harm? Sometimes achieving one good may require compromising, at least to some degree, another. When goods are in tension like this, we should strive to preserve as much of each as possible, instead of sacrificing one entirely to achieve the other. (p. 37)

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What Can the Church Do?

> *Come to me, all you that are weary and are carrying heavy burdens, and I will give you rest.*
> (Matthew 11:28, NRSV)

For many who live with serious mental illness, life can include homelessness, addiction, suicidal thoughts, discrimination, families in pain, violence, and barriers to employment and mental health services. These are shaped by gender, race, and age, and are especially challenging for people seeking ordination or who are already ordained. Yet God does not abandon us, God is with us still. We can proclaim to people living with serious mental illness the words of the prophet Isaiah, "The people who walked in darkness have seen a great light; those who lived in a land of deep darkness—on them light has shined" (Isaiah 9:2, NRSV). Congregations can offer fruitful and faithful ways to respond in ministry to people with serious mental illness:

- Offer basic services and space for people living with mental illness

  Churches could serve meals to the hungry, provide shelter for the homeless, or provide space in their buildings for support groups or recreational activities for people with mental illness. Churches could also offer space for support groups for families and caregivers of those living with mental illness. Such direct services are a vital link to God's comfort for many who live with mental illness every day. Not only do they provide specific forms of care, but they do so in the name of Christ, and thus offer a sign of his resurrection power to those in pain. (p. 45)

- Affirm the church's historic ministry of healing by holding healing services and prayer-based support groups which include those with mental illness

  Churches enable recovery when we welcome people with serious mental illness into our faith communities. While churches cannot cure mental illness, they can work with a person with mental illness toward their unique recovery goals. One such way of walking with individuals who have mental illness is to offer a service for wholeness and healing that is in accordance with the Scriptures, such as James 5:13–16. Such services for wholeness could be provided within community and to individuals in conjunction with appropriate (medical and psychological) clinical treatment. (p. 48) Prayer-based support groups recognize the genetic, biological, and social aspects of mental illness, yet keep their focus on the redemptive and restorative work of Christ to help people heal from life's wounds. While many different kinds of groups can help people with mental illness, prayer groups offer a spiritual balm that others cannot provide. Prayer groups include a time for sharing in confidence and a time for praying for each other. Through these gatherings many have found healing for body, soul, and spirit. Prayer groups enable the church to proclaim hope for the despondent, clarity for the confused, and a peace that passes understanding, all through the power of the living God. (p. 44)

- Offer educational opportunities on the topic of mental illness

  Some churches have been inspired to be involved in ministry with persons with serious mental illness through sermons, Bible studies, or Sunday school discussions. Their pastors and teachers have informed them of various kinds of mental illness, and related this psychological information to biblical mandates for compassion, tolerance, and justice. This education encouraged many people to share stories of their own experience of mental illness, or that of loved ones or friends. Education sometimes moved church members to become activists, reformers in the field of mental health, because it awakened them to how widespread mental illness is. They began to see that they would have allies in this ministry, and experienced new enthusiasm for it. In this sense, education is a transforming experience. It involves the transformation of the stranger with serious mental illness into a neighbour, a friend, a sibling, a member of the Body of Christ. Education is much more than the transfer of information; it is rather an invitation to a relationship with someone with a serious mental illness. It is an experience of the scales falling from our eyes so that we see the full humanity of all who live with serious mental illness. (Acts 9:18) (p. 45)

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A Ministry Both Challenging and Rewarding

Patience and Perseverance

Many people with serious mental illness who attend church elect not to disclose their illness. They participate in church life without any church members knowing of their illness. When a church

welcomes persons who struggle more openly with a serious mental illness and whose symptoms may be more apparent, there will be both blessings and difficulties. Persons with cognitive and emotional problems can be trying. For example, a Bible class that feels held back by a member who almost continually complains about his inadequacies must learn to consider their relationship with him or her just as important as the chapter they are attempting to cover. At the same time, some people with mental illness can benefit from loving and constructive feedback regarding appropriate group behaviour. Churches have often found that the gospel of Jesus Christ becomes less doctrinal and more incarnational as they persevere in the deeply compassionate way of their Lord.

Mixed Feelings

While church members often have positive feelings when they get involved in ministry with people with serious mental illness, they may have negative ones too; and sometimes they deny the negative ones. Denial is likely to weaken ministries for people living with serious mental illness. Tasks first undertaken with alacrity and enthusiasm can devolve into laborious obligations. Then energy flags and ministries and people suffer.

Mixed feelings are a normal part of many human experiences. Ministry with people with serious mental illness is no exception, especially when one chooses deeper levels of involvement. When these mixed feelings are acknowledged and carefully examined, they enhance both the personal growth of the person providing the ministry as well as the one receiving it. For instance, ministering with a person with severe depression can evoke awareness of one's own grief, or ministering with a person with severe panic attacks may bring up one's hidden anxieties. Recognition and deeper understanding of these feelings can bring healing and wholeness to both the one ministering and to the one receiving care. The following are typical feelings that can hamper ministry. (p. 46)

Some church members find that they must deal with their fear of persons with mental illness. Such fear often decreases with greater understanding of mental illness. The fear can also be addressed by remembering that persons with mental illness rarely physically harm others. Also, churches can assuage this fear by making sure that experienced staff is present when support groups for people living with mental illness are meeting in church buildings. Often people do not know what to say to a person with mental illness. To treat persons who have a mental illness with kindness and compassion will help, but hearing their life stories will greatly reduce one's anxiety. The more familiar people are with each other the more comfortable they will be.

Discomfort

Discomfort is a common response to persons with mental illness. It may lead to feelings of repulsion that result in rejection. People with mental illness may act differently, speak differently, dress differently, appear disheveled and have poor personal hygiene. They may also have unusual mannerisms, idiosyncratic behaviours, and unconventional habits. While many people cannot be expected to just overlook these marked differences, seeing people as individuals can lead to an acceptance of some differences and create greater openness to a fuller range of human experience.

Anger

Anger is another common response. Those who perceive people with mental illness as lazy and "just looking for a hand out" will often respond with frustration or even anger. It is important to separate the person from the illness, by getting frustrated with the illness and not the person. Setting firm and appropriate interpersonal boundaries can also help to reduce frustration and anger, because boundaries give caregivers personal space. Healthy boundaries also train people with mental illness to gauge how their behaviour affects others, so that they can develop more positive habits.

Powerlessness

In an ongoing relation with a person who suffers with serious mental illness, a common impulse is to try to "fix" the problem, to make the suffering go away. However, because it is not possible for human beings to eliminate the problem of serious mental illness, caregivers often feel powerless and helpless in the face of such suffering. This feeling of powerlessness can be very painful. The challenge, then, is to learn to tolerate these feelings in order to be able to stay present and to offer the gift of friendship. When one's powerlessness is accepted, and the pain of it is tolerated, then the caregiver may find a source of power that is beyond the realm of the human and from the realm of the divine. The paradox of powerlessness is such that only in recognizing one's powerlessness does one embrace the Source of all Power.

Faith and Joy

As a community of faith, we are called to live out our faith in practical ways. Ministry to those living with mental illness can challenge us to do this. Faith can become dry and dreary, theology can become abstract, and expressions of faith can become mere routine. But in demanding and sometimes difficult service to others, faith is made vividly alive and particularly relevant. Through active service to those with serious mental illness the lives of both the giver and receiver of that service are enriched and both draw closer to God.

Ministering to others can fill life with love and joy, even with excitement. When a sibling with a serious mental illness is recognized and greeted by name, the joy of that simple act is equally experienced by both. Kindness is contagious. Individuals, families, and faith communities all grow when the stranger becomes friend. (adapted from p. 47)

APPENDIX D – MENTAL HEALTH RESOURCES FOR CLERGY

> *[8]Then Amalek came and fought with Israel at Rephidim. [9]Moses said to Joshua, "Choose some men for us and go out, fight with Amalek. Tomorrow I will stand on the top of the hill with the staff of God in my hand." [10]So Joshua did as Moses told him, and fought with Amalek, while Moses, Aaron, and Hur went up to the top of the hill. [11]Whenever Moses held up his hand, Israel prevailed; and whenever he lowered his hand, Amalek prevailed. [12]But Moses' hands grew weary; so they took a stone and put it under him, and he sat on it. Aaron and Hur held up his hands, one on one side, and the other on the other side; so his hands were steady until the sun set. [13]And Joshua defeated Amalek and his people with the sword.*
> (Exodus 17:8–13, NRSV)

The image of Moses with heavy arms in this passage reminds us that leaders can grow weary in ministry. Ministry can be joyful and uplifting. Every minister can share stories of how God's grace and love has touched their lives and the lives of those they serve in remarkable ways. But sometimes ministry can feel like a long haul – or even like a battle. It can take a toll on physical health as ministers experience fatigue, sleeplessness, headaches, hypertension, and a host of stress-related conditions. It can also take a toll on mental health as ministers experience anxiety, depression, irritability, anger, burnout, addictions, and substance abuse. Who ministers to the minister? Who holds up their arms in the battle when they grow weary? What resources are there to support clergy mental health?

The Presbyterian Church in Canada offers resources to encourage clergy self-care and promote good mental health, as well as to assist those struggling with mental health issues on their journey to healing and wholeness. Some of these provisions are ordinary, perhaps not even recognized at first as contributing to good mental health. Others are special provisions for those who need individual care.

One of the greatest impediments to clergy and professional church workers seeking out resources and support for mental health is the stigma attached to mental health issues. Fortunately, this is beginning to change; but we have a long way to go yet. Mental health issues are regarded differently. No one questions a person with a broken arm in a cast. But if somebody has a broken psyche – if somebody is dealing with depression, or bipolar disorder – we can fail to offer the same understanding and concern. Too often people with mental health issues are regarded as weak, or somehow lacking in faith, or considered deficient in a way that makes them unable to be effective as ministers. This contributes to a climate where wounded clergy and church leaders keep silent about their pain – of if they do open up to someone, it is with embarrassment and shame: "You can't tell anyone about this."

Some of our best and brightest church leaders struggle with mental health issues. Some of our most creative, most gifted, and most effective ministers have mental health issues they have learned to manage, just as those who have diabetes or asthma have learned to manage their physical health issues. Some of these church leaders have bravely and openly talked about their situations and shared their experiences. This has been a great gift to the church. In doing so they have opened the way for more honest conversations about mental health in the church. Conversations like this can lead to the realization there are far more individuals in the church managing mental health conditions than we might think. It can also lead those who are struggling with mental health issues to understand: YOU ARE NOT ALONE. We are all, in our own brokenness, part of Christ's church, which at its best is a loving, caring, supportive, healing community of faith.

But we have this treasure in clay jars, so that it may be made clear that this extraordinary power belongs to God and does not come from us. (2 Corinthians 4:7, NRSV)

Ordinary and special provisions to promote good mental health

Sabbath Time

- In the Ten Commandments, God instructs us to remember and observe one day out of seven as a time when no work was to be done (Exodus 20:8–11; Deuteronomy 5:12–15). Sabbath times of rest and renewal are important for good mental health. Some of these provisions are included in the terms of a minister's call. Ministers are encouraged to:
  - take at least one day a week off
  - take their full vacation each year (the General Assembly minimum is 5 weeks, including 5 Sundays per year)
  - use their study leave regularly (see the Minimum Stipends and Allowances Schedule published in the Acts and Proceedings yearly for the General Assembly approved minimum study leave time and allowance).
- It is important for ministers to regularly take time away from the church for themselves and their families.

Colleague Covenant Groups

- This program is administered by Ministry and Church Vocations to promote the creation of peer support groups where clergy can gather regularly to share the joys and challenges of ministry and provide mutual support and encouragement for one another. It provides initial start-up funding of $600 for a group project. Information is available on the Ministry and Church Vocations web page (presbyterian.ca/mcv/).

Inter-Mission

- A program approved by the General Assembly in 1992, it is a ten-week self-funded sabbatical time for personal spiritual renewal. It is intended to be "a time to get in touch with the Holy Other in our lives."
- An inter-mission requires advance planning and preparation, usually about a year. Information is available on the Ministry and Church Vocations web page (presbyterian.ca/mcv/).

Special provisions to assist those needing individual care

EAP (Employee Assistance Program)

- Administered through the Pension and Benefits Office
- Provides confidential intake and referral to short-term counselling services, and other services (legal, financial, etc.). Strictly confidential.
- Available to the minister and their immediate family members (anyone covered by the SunLife plan) 24 hours a day, seven days a week, by phone or online.
- Information is available here: presbyterian.ca/pensionandbenefits/active-members/

SunLife Health Care Benefits

- Covers 100% up to a combined total of $700 per person per benefit year for psychoanalysis treatment.
- More information is available in the SunLife Group Benefits Plan Booklet here: presbyterian.ca/pensionandbenefits/active-members/

Special Counselling Fund administered by Ministry and Church Vocations

- Ministry and Church Vocations has some funds set aside to provide some financial assistance for short-term counselling for ministers (or their families) if the SunLife Benefits are not sufficient. Contact the Associate Secretary, Ministry and Church Vocations, for more information.

Short-Term and Long-Term Medical Leaves

- The Presbyterian Church in Canada has a Sick Leave Policy for all professional church workers (presbyterian.ca/pensionandbenefits/active-members/).
- During a minister's medical leave, congregations may apply to the Pension and Benefits Office for pulpit supply insurance. Pulpit supply insurance is paid when the professional church worker is unable to work due to illness or accident. Pulpit supply insurance provides the amount for pulpit supply approved by General Assembly, plus travel ($25), per Sunday for a maximum of 17 weeks.

ENDNOTES

[1] Living Faith: A Statement of Christian Belief, 7.1.1.

[2] Canadian Mental Health Association, cmha.ca, FAQ, "What is mental health?"

[3] For more information, see presbyterian.ca/mcv/colleague-covenant-group-grants/

[4] pcusa.org/resource/comfort-my-people-policty-statement-serious-mental/

[5] camh.ca/en/camh-news-and-stories/common-myths-about-mental-illness, accessed November 2, 2022