# Doctoral Project Approval Sheet

This doctoral project entitled

MENTAL HEALTH MINISTRY AT THE ROYALE THERAPEUTIC RESIDENTIAL
CENTER AND OCEANVIEW ADULT PSYCHIATRIC HOSPITAL

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TAKING CHURCH TO THE MENTALLY ILL: MENTAL HEALTH MINISTRY AT
THE ROYALE THERAPEUTIC RESIDENTIAL CENTER IN ORANGE COUNTY,
CALIFORNIA AND OCEANVIEW ADULT PSYCHIATRIC HOSPITAL IN
LONG BEACH, CALIFORNIA

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ABSTRACT

**Taking Church to the Mentally Ill: Mental Health Ministry at the Royale Therapeutic Residential Center in Orange County, California and Oceanview Adult Psychiatric Hospital in Long Beach, California**
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This project seeks to find ways for the church to engage with those who are mentally ill residing in mental health facilities. The goal is to provide residents with opportunities for spiritual formation and growth. To support this effort, I conducted worship services at two mental health facilities to determine whether taking church to the mentally ill can contribute to creating a Christ-centered community for the mentally ill. The project started with a planning phase emphasizing the specifics for developing an appropriate worship content and approach, including the length of the service, the message, music, and other attributes. Observations, comments, suggestions, and recommendations were collected during the worship services, and updates were incorporated to better serve the worshipers.

The findings suggest the majority of the residents who attended the worship services felt a sense of being in a Christ-centered community. The ability to participate during worship, have input on praise music, share prayer requests, and receive communion created significant value and contributed to the residents' spiritual formation. One of the most significant findings and reflections is the notion of hospitality. The initial assumption is that the church is offering hospitality to those residing at mental health facilities. Instead, the hospitality is offered by those who are already in this community to the church. Going forward, the hope is to replicate this type of ministry at other mental health facilities and to approach behavioral health authorities to encourage incorporating spiritual components into their mental health programs.

Content Reader: Richard Beck

Words: 245

This project is dedicated to my wife Jana for gracefully showing the true meaning of unconditional love in the midst a broken world. To our dear Leah and all who are impacted by mental illness, may you find your God-given gifts and use them to make a difference in the world.

ACKNOWLEDGEMENTS

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MINISTRY CONTEXT

INTRODUCTION

The purpose of this project is to create an on-site ministry for the mentally ill at the Royale Therapeutic Residential Center in Orange County, California. The goal is to develop a model for bringing church to those who are not able to come to church due to limitations attributed to mental illness. This would include those who are physically not able as well as many who may be emotionally and mentally unable. In many cases, the mentally ill are reluctant to go to church due to the stigma placed upon them by the church. They feel unwelcomed and unwanted. They believe they are not worthy of being in the presence of God because they are unclean. For those who have severe mental illness, this is especially the case. This project intends to develop collaborative and welcoming ways to bring church to those who are marginalized due to mental illness, regardless of their circumstances.

The Royale Therapeutic Residential Center in Orange County, California, predominately serves the mentally ill in the county. Royale is a secured lock-down facility where the mentally ill residents have very little access to the outside world. During a resident's stay, exposure to the outside world is limited to visits from immediate family members and volunteers willing to visit the facility. This can lead the residents to loneliness, isolation, and even a sense of abandonment

For the residents, there is very little if any opportunity for spiritual formation and growth as they have limited access to church activities such as worship services, small groups, and other forms of fellowship. This project will develop a plan for the Shepherd

of the Hills United Methodist Church (SOTH) to bring worship and fellowship to the residents at Royale.

Spirituality can be a significant component of a comprehensive treatment program for the mentally ill. Such a plan would encompass a whole person approach, including medical treatment, addiction/substance abuse, the person's physical well-being, and their spirituality. However, there are no such explicitly designated worship services at Royale, which is a significant gap in the current system. A mental illness ministry can be a part of filling this gap in the current mental illness treatment programs in Orange County.

With no opportunities for worship, there are very few, if any, opportunities for spiritual formation and growth. This project focuses on providing worship services and other ministry attributes to the residents at Royale. Due to various constraints, the conventional worship model is not suitable for this and similar settings. This is very likely one of the reasons those who are mentally ill refrain from going to worship on Sunday. Some of the constraints are related to the physical, emotional, and mental limitations of the ill individual. For instance, someone with a mental illness may not be able to sit through an entire worship service. They may become bored and uninterested. They may display behavior uncharacteristic of typical churchgoers. As such, the mentally ill may feel alienated and out of place as if they do not belong. They may even believe that they do not belong in a church and so are not interested in being singled out. Many churches also contribute to causing them to refrain from attending church services. Some churches do not understand mental illness. As such, they show less tolerance toward the mentally ill and are not prepared to properly manage disruptions, movements, and the

sight of mentally ill people at worship services. In essence, churches can be a contributor

towards the absence of the mentally ill at services. For these and many other reasons, this

project intends to bring church to the mentally ill in a safe space where there is no stigma,

judgment, or criticism—a place where they are free to worship and come as they are to be

in the presence of God and to fellowship with others.

The importance of this project cannot be understated. In many respects, mental

illness poses unique challenges. Unlike many other conditions, mental illness can, by its

nature, impede a person's ability to make decisions about their care. Mental illness also

presents a challenge to society. It can significantly disrupt communities.[1]

For this project, there are many significant aspects to consider. First, this project

contributes to the existing body of knowledge on the church and mental illness. There is a

need for the church to understand better and appreciate this debilitating disease that has

become a national crisis. Second, beyond a clear comprehension of this crisis, the church

needs to be able to offer a proper response in line with the true essence of the church as

the body of Christ. The church's response should be such that the unconditional love,

compassion, grace, and mercy that can only come from God are clearly visible to all. This

would mean that the church develops relationships with the mentally ill and is a part of

the healing process. From this perspective, the church becomes a relational church and is

an essential component of the community. The purpose of the church becomes apparent,

and the church is acting in concert with the world as opposed to being segregated from

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[1] R. G. Frank and S. A. Glied, *Better But Not Well: Mental Health Policy in the United States Since 1950* (Baltimore: Johns Hopkins University Press. 2017), chpt. 1, Kindle.

the secular world. Third, this project can be a pathway to rekindle lost relationships with loved ones suffering from mental illness, and ease the pain of loneliness and hopelessness for the mentally ill and their loved ones. In many ways, this can be a pathway to restore relationships and bring hope. This effort can demonstrate how the mentally ill can develop a sense of purpose when participating in a ministry of their own. Finally, the findings from this project can also provide insights into how the church can be blessed and receive the gifts the mentally ill can bring to church. One option the church can consider is to utilize those who have acquired competency and experience in mental health ministries to serve as companions for mentally ill persons during the worship services.

As stated, this project has the potential to offer many significant benefits, including contributing to the body of knowledge in the field of mental illness and faith. This project can assist with re-establishing the true identity of the church as the body of Christ and all of the redeeming values that can only come from Christ. Additionally, it can also be a part of a comprehensive overall treatment plan in which spirituality has an equal stake with other factors such as the treatment of the illness itself, substance abuse, and the personal well-being of the individual. Lastly, it can be a part of the healing process.

Personally, this project is significant for me because one of our children has a mental illness. For over a decade, my family has experienced the trials and tribulations associated with having a mentally ill family member. Mental illness impacts the entire family and can change family dynamics in an instant. My family has experienced the

weak and failing mental health system at the national, state, and local levels. We have

personally witnessed the pain, agony, and frustration encountered by the mentally ill

individual and family members in our poorly-managed mental health system. We also

had the first-hand experience of being exposed to the stigma and trauma of mental illness.

We are experiencing the double-edged sword effect from a mentally ill loved one. This

double-edged sword refers to the behaviors that are gained and lost by a loved one.

Behaviors gained are those never seen before. These can range from poor hygiene and

restlessness to violence and other unsavory actions. Behaviors lost are the loved and

cherished behaviors one's loved one had until developing mental illness. Everything one

loved about the individual is now gone.

Spiritually, families like ours have experienced feelings of being separated from

God. At times, it seems as if God does not exist. It does not seem logical that a

compassionate and unconditionally loving God would allow mental illness to plague

humans and render some people totally unable to provide for themselves such that their

family ties are severed, and they become homeless. In cases of severe mental illness, the

ill individual is often isolated and marginalized. Loneliness quickly sets in as their trusted

relationships may no longer exist. It seems that the unconditionally loving God allows

this and other tragic events to take place.

When we shared our story at church, some of our friends prayed for us and then

retreated from us due to ignorance and lack of understanding as if we had the plague, and

will avoid us. Having a conversation about mental illness makes some people very

uncomfortable. Perhaps these individuals are living in similar situations and are not

willing to share their own stories for fear of being singled out. These and other similar circumstances are indicative of the mental illness stigma in many churches. Stigma leads to a void for those who are desperate and need spiritual support. With no help from the church, many families leave the church and seldom return.

For these and similar reasons, this project proposes to develop a plan to bring church to those who may not have the opportunity to go to church, do not want to go to church because they do not want to be singled out, and may not be able to withstand sitting through an entire worship service. The hope is to be able to develop a viable methodology at Royale and then replicate this at other mental health facilities. Ideally, this project will develop a model as a guide for others who may be interested in similar ministries.

The goal then is to develop a worship service specific to residents at mental health facilities with consideration for their physical, emotional, and mental limitations. The concept would be to bring church to the mentally ill so they can worship as they are and where they are. The liturgy would be customized, and the length of the worship is shortened, which means the traditional liturgy may need to be modified to fit the needs of the worshippers.

To summarize, my reason and desire to conduct this project are two-fold. First, I want to reach out to those who may not have the opportunity to attend church. Second, this is a personal journey of healing and serving God, of learning to become a wounded healer and serve the mentally ill as described by Henri Nouwen.[2]

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[2] Henri Nouwen, *The Wounded Healer: Ministry in Contemporary Society*. (New York: Random House, 2013), chpt. 1, Kindle.

This project will consist of three parts. Part one is an introduction to the current situation. This includes a brief overview and demographic assessment of SOTH and its perspective on reaching out to the mentally ill. This introduction also provides an overview of mental illness from the community at large, including the way mental illness is perceived. Lastly, I will offer an assessment and a discussion of Royale with a focus on their ability to fulfill the spiritual needs of the residents.

Part two is a theological reflection on faith and mental illness. This section begins with a review of related literature, including mental illness ministries, faith and its role in mental illness treatments, and the church as a part of the overall mental illness solution. This is followed by a review of Scripture passages that demonstrates Jesus Christ as a healer. Specifically, how did Jesus heal, and what did Jesus' disciples learn about healing from him?

Part three is the ministry plan and the implementation of this plan. This section will include discussions relevant to planning for the specifics and uniqueness of a mental illness ministry. Additionally, this section will also include descriptions for ways to engage family, friends, and supporters from the community. Lastly, I offer a discussion on the implementation of the project, including liturgy, schedules, logistics, and support networks needed.

CHAPTER ONE:
MENTAL ILLNESS CRISIS AND ITS IMPLICATIONS
IN ORANGE COUNTY, CALIFORNIA

This section is an overview of the mental illness crisis in Orange County,

California. Mental illness does not discriminate, and the impacts of this debilitating

illness cut across the entire spectrum of everyday life in Orange County.[1] Without a

doubt, mental illness affects those who are mentally ill, their families, and their friends.

Additionally, mental illness also impacts county public services such as law enforcement,

medical facility, social services, and other agencies. Mental illness also involves

businesses as the mentally ill can easily interrupt the operations of an establishment,

affect clients, and produce financial consequences.[2]

This review begins with an introduction to Shepherd of the Hills United

Methodist Church (SOTH), including an assessment of the current outreach programs, as

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[1] Nick Gera, "Greater Focus on Mental Health Care in OC, but Progress Remains Slow," *Voice of OC,* September 21, 2016, https://voiceofoc.org/2016/09/more-focus-on-mental-health-care-in-oc-but-progress-remains-slow/.

[2] *Orange County Community Indicator Report, 2017* (Santa Ana, CA: Orange County Health Care Agency, 2017), 62-63. http://www.ochealthiertogether.org/content/sites/ochca/Local_Reports/OC_Community_Indicators_2017.pdf.

well as SOTH's views on mental illness. There is an overview of Orange County, California. Specifically, a brief description of Orange County, including its multi-cultured diversity and its ever-changing demographics. I will also offer an assessment of the current Orange County Behavioral Health Services, including the treatment of mental illness and the homeless crisis, where mental illness plays a significant factor in Orange County. Lastly, there will be a brief introduction to the Royale Therapeutic Resident Center.

## Shepherd of the Hills United Methodist Church

Shepherd of the Hills (SOTH) is a United Methodist Church (UMC) in Mission Viejo, California. It just celebrated fifty years of service in the community. SOTH currently has two campuses in Orange County, California: one in Mission Viejo, and one in Rancho Santa Margarita. The two campuses, although relatively close in vicinity, have similarities and distinct differences. At the Mission Viejo Campus, the majority of the congregants are retired and are predominately white middle-class. Most of this population settled in Mission Viejo during the start-up of the Mission Viejo land development in the 1970s. The church was planted during that time and has grown over the years. Many in this first wave of church members faithfully served the church and raised their children in the typical church family tradition. The elderly population is in decline due to death and disabilities. The elderly who are disabled may have limited mobility, which leaves them home-bound or in senior living facilities and unable to come to church. The traditions from the early days of the church still resonate as many in the first wave and some of

their children, who are now adults with their children, still participate regularly in church activities, including decision-making processes.

At the Rancho Santa Margarita campus, the majority of the congregants are also white middle-class. The church population at this campus is younger than at Mission Viejo, as this housing development developed at a later time. This campus tends to be more inclusive, more receptive to diversity in the congregation, and more outwardly focused. There are fewer small groups at this campus as many of the congregants are busy during weekdays working and caring for their children in the evenings. A relatively new hospitality initiative at this campus is the weekly "Community Table" on Wednesday nights. The intent is to invite everyone from the community to share a meal and foster relationships. Some come for fellowship, some come to meet new friends, some come because they are lonely, and some may come for a meal to make ends meet. Regardless of why people are coming, all are welcome.

For the most part, hospitality focuses on serving the majority of those coming to church. The trend has been on creating an inviting environment for people to come to church, which is the traditional model for most churches with similar demographics and geographic locations. Unfortunately, changes in demographics, dynamics of the family nucleus, and changes in family priorities are not conducive to churchgoing.[3] In other words, attending church is no longer a top priority for most people in the community.[4] In

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[3] Christine Pohl, *Making Room: Recovering Hospitality as a Christian Tradition* (Grand Rapids, MI: Eerdmans, 1999), chap. 4, Kindle.

[4] John Drane, *The McDonaldization of the Church: Consumer Culture and the Church's Future* (Macon, GA: Smyth and Helwys, 2001), 3.

fact, they may feel unwelcome as they may not fit the expected image of a churchgoer. It may be time to reconsider hospitality and how these two campuses offer hospitality and welcome strangers. Christine Pohl submits that hospitality is not optional for Christians; it is a necessary practice.[5]

## Outreach Programs at SOTH

A small group of members volunteers for outreach ministries at SOTH. This is typical of many churches of similar size in the area and is due to the lack of people who are willing and/or able to volunteer for outreach programs. To compensate, the church funds external outreach programs as opposed to having its own outreach programs. This is a way to support the needs in the community without having to significantly rely on the time and resources of the volunteers. In many instances, the church just does not have enough people to satisfy all the needs in the community. Supporting community outreach programs seems to be an excellent way to share resources from many faith organizations to support the various spiritual needs of the community. No doubt these and similar options provide necessary financial resources to the many outreach organizations. However, these types of programs do not adequately address Christian hospitality in its entirety. This is especially true for people who are mentally ill and require long-term support. Most churches do not have the infrastructure to offer the more extended duration support needed for the mentally ill. In the next section, a discussion on SOTH's view on

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[5] Pohl, *Making Room,* chap. 2.

mental illness is offered to provide a further understanding of why SOTH is not prepared to support the needs of the mentally ill.

Shepherd of The Hills' Views on Mental Illness

SOTH is aware of the mental illness crisis as many informal discussions take place during coffee time and at Bible studies. However, it appears the church has no formal outreach towards the mentally ill. There seems to be a reluctance to engage in mental illness ministries. Some of the congregants appear to be willing to participate but do not seem to know how to engage. Other congregants do not seem to have any interest in engaging as they believe this is a problem created by the individual or by the family dynamics.[6] Stigma and misunderstanding about mental illness is likely a significant factor in the reluctance to engage. Amy Simson describes this in detail in her book *Troubled Mind*. An entire chapter titled "Church Life" provides insights into why churches are reluctant to engage in mental health ministries.[7] Many inaccurate stereotypical attitudes toward mental illness such as blaming the individual's illness on addiction and laziness and blaming the parents for mistreating the individual contributes to the reluctance. There may also be a psychological component to congregants' unwillingness to engage, described by Richard Beck as the psychology of disgust.[8] This phenomenon is a

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[6] Amy Simpson, *Troubled Mind: Mental Illness and the Church's Mission* (Downers Grove: IL: InterVarsity Press, 2013), 98-101.

[7] Ibid., 97-120.

[8] Richard Beck, *Unclean: Meditations on Purity, Hospitality, and Mortality* (Eugene, OR: Cascade Books, 2011), 1.

psychological obstacle that limits a person's ability to reach out to the marginalized such as the homeless and the mentally ill. In other words, humans may be pre-disposed to not engage as humans.

The ways SOTH operates and functions are typical of the majority of community churches of similar size in the region.[9] That said, the level of support from churches to the mentally ill can be improved upon. This does not mean SOTH is not willing to better serve the marginalized and offer them hospitality. Instead, there may be a lack of understanding and know-how on providing hospitality to the mentally ill. In chapter five, there will be a discussion on ways for churches to appreciate and embrace ministries for the mentally ill. In the next section, an assessment of the mental illness in Orange County, California, is presented.

## The National Mental Illness Crisis

In modern times, the mentally ill were institutionalized and put into mental wards or hospitals.[10] This isolation approach was the standard for many who did not have family members willing to care for them. However, this approach not only marginalized the mentally ill, it also took them away from the public eye as if mental illness did not exist in society. In the latter part of the twentieth century, there was a movement to reconsider the treatment for the mentally ill. Many thought mental wards were inhumane

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[9] Joel Kotkin. "Is the End Near for Religion?" *Orange County Register,* December 25, 2017. https://www.ocregister.com/2017/12/23/is-the-end-near-for-religion/.

[10] F.E. Torrey, *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System* (New York: Oxford University Press, 2014), 84-85, Kindle.

as the mentally ill were separated from their family, friends, and communities. President

Jimmy Carter put the Mental Health System Act (MHSA) in place in 1979,[11] closing

many mental wards, and initiated a program to relocate the mentally ill back into their

home communities. Funds allocated to the psychiatric wards would be rechanneled to the

local communities to provide them with the necessary funds to provide the required

support to the mentally ill in their home communities. This was thought to be a more

humane approach to the treatment of the mentally ill.

When Ronald Reagan was the governor of California, he began the de-

institutionalization of the mental health system and closed many mental health hospitals

in California.[12] Reagan continued this process when he became the president of the

United States. President Reagan also repealed the Mental Health System Act (MHSA),

which ended funding to local mental health services. This meant two things were put in

place. The first was the de-institutionalization of mental health facilities, and the second

was the defunding of the local mental health agencies meant to provide the necessary

services to the mentally ill in their respective communities.

These two initiatives together were a double-edged sword. By 1981, the mental

health system at the national and state level had disappeared, which ended the national

safety net system for the mentally ill.[13] Deinstitutionalization was meant to promote a

more humane approach, through which the mentally ill would be provided with an

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[11] Ibid., 87.

[12] Torrey, *American Psychosis*, 84-90.

[13] Ibid., 89.

opportunity to return to their homes and seek regionalized and local mental health support. Unfortunately, defunding of regional and local agencies caused a void in the system, which led to insufficient funding at the local level to accommodate the needs of the mentally ill. The goal was to de-institutionalize the national mental health system and provide opportunities for recovery as individuals with a sense of independence, freedom, and dignity. Instead, the national mental health system is in disarray and has failed those it meant to serve. In essence, the mental health system is broken, and there are many voids in the system, starting from the mental health care agencies and bleeding into social services, health systems, the criminal justice system, and many other agencies.

This is evident when a mentally ill person cannot receive proper care until they are in the criminal justice system.[14] Many desperate parents are told that the best way for their children to receive help is when they enter the criminal justice system and are put in prison.[15] Something is wrong when parents are told their mentally ill adult child needs to be jailed in order to get help. For many, this is an outrage. Even without a viable comprehensive mental health program at the national, state, and local levels, many agencies and facilities are doing their best and are claiming small victories for their efforts. Some faith-based organizations—typically those who have experienced the impact of mental illness—have also engaged with some success.  However, this nation

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[14] Jocelyn Wiener, "All Too Often, California's Default Mental Institutions Are Now Jails and Prisons," *Cal Matters*, February 4, 2019. https://calmatters.org/projects/california-mental-health-treatment-in-prisons/

[15] Gera, "Greater Focus on Mental Health Care."

lacks a viable, comprehensive, long-term mental health solution. This void is one of the major factors contributing to the mental health crisis.

The section provides an overview of Orange County, California. Orange County borders Los Angeles County and is also close to San Diego County. Its location brings both advantages and disadvantages.

## Orange County California

Orange County, California, is the home of Disneyland, the Los Angeles Angels baseball team, the University of California Irvine (UCI), Huntington Beach, "Surf City," Newport Beach, and many other tourist attractions. Orange County's population of approximately 3.5 million has been shifting with an increase in Latin American, Asian American, and Middle Eastern American populations.[16] The "Baby Boomer" generation is retiring at a steady pace. Jobs have shifted from farming and manufacturing to tourism and service industries. Orange County has traditionally been conservative politically, but there has been a shift in the political climate with an increase in liberal politics.[17] The combination of the changes in the social, political, and economic arenas has created a much more competitive environment at all levels, impacting the physical, emotional, and mental well-being of the county's population. Unfortunately, some of the downside effects of this shift are substance abuse, homelessness, and mental health disorders. Like

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[16] Mark Baldassare, "Tectonic Shifts in Orange County," Public Policy Institute of California, October 8, 2018.  https://www.ppic.org/blog/tectonic-shifts-in-orange-county/.

[17] Michael Blood, "As Demographics Change in Orange County, So Do Its Politics" Associated Press. October 17, 2018. https://www.csmonitor.com/USA/Politics/2018/1017/As-demographics-change-in-Orange-County-so-do-its-politics.

many counties in California, Orange County is struggling with the challenges associated with these downside effects. One of the major challenges is the growing homeless population. Many in this population are mentally ill.[18] Although Orange County recognizes the need to address the homeless population, many of the cities and municipalities are reluctant to provide the necessary housing and other associated support.[19]

It appears that Orange County is well aware of the ever-changing social, economic, and political climate. The county is also cognizant of the need to address some of the downside issues such as homelessness, substance abuse, and mental illness.  In the next section, a focused discussion on the Mental Health Services in Orange County, which is the primary source for addressing mental illness in the county, is offered.

## Mental Health Services in Orange County

There are both public and private mental health services in Orange County. For instance, there are over 200 contracted behavioral health services in the county.[20] This has led to confusion and added complexity for those who require mental health services. It is difficult enough for a normal person to navigate this complex system; imagine what

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[18]Andrew Do, "Ending Mental Health Stigma," OCgov.com, accessed January 14, 2020, https://media.ocgov.com/gov/bos/1/newsletter/op_ed/ending_mental_health_stigma.asp.

[19] Jill Replogle, "Is Orange County Turning the Corner on Homelessness?" March 5, 2018, 89.3 KPCC, https://www.scpr.org/news/2018/03/05/81292/is-orange-county-turning-the-corner-on-homelessnes/.

[20] OC Health Care Agency, "OC Links Three-Year Anniversary: Statistics from October 2013 to October 2016," OCgov.com, accessed January 14, 2020, http://www.ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=59970.

it must be like for someone with a mental illness. With the current system, the focus and success measurements are the number of contracted behavioral health services in the county. There is minimal emphasis on the number of patients recovering from mental illness.[21] Public opinion in Orange County views the county's management of mental illness as unsatisfactory. This is evident by the below-par response to the recent homeless encampments, substance abuse, and mental illness crisis in the county. While the magnitude of the crisis and the need to assist are understood, there is still a reluctance to support a proper comprehensive solution. In many of the local cities and municipalities, NIMBY "Not in My Back Yard" seems to be a common theme.[22] The idea of a comprehensive wrap-around solution still remains elusive. Recently, glimpses of hope have been emerging. Orange County started a program called "Be Well."[23] This program will provide a full wrap-around service to the mentally ill beyond providing housing, as the intent is to provide medical services, psychological services, therapy, mindfulness, hygiene, well-being, and vocational assistance. Although this program is currently in its infancy, it is a positive move for the county.

Orange County seems to recognize the mental illness crisis and is looking for possible solutions. Unfortunately, a viable solution is currently not available. The next

[21] OC Social Services Agency, *Annual Report: Fiscal Year 2017-2018*, County of Orange Social Services Agency, accessed January 14, 2020, http://ssa.ocgov.com/civicax/filebank/blobdload.aspx?BlobID=61674.

[22] Michael Lopez, "Shortsightedness and a Continued NIMBY Culture," *Voice of OC,* June 3, 2018, https://voiceofoc.org/2018/06/lopez-shortsightedness-and-a-continued-nimby-culture/.

[23] Ashley Ludwig, "Be Well Mental Health Facility Will Be First of Its Kind," *Patch*, January 29, 2019, https://patch.com/california/lakeforest-ca/be-well-mental-health-facility-will-be-first-its-kind.

section is an overview of the Royale Therapeutic Residential Center and its role in serving the mentally ill in the community.

## The Royale Therapeutic Residential Center

The Royale Therapeutic Residential Center is one of a handful of mental illness treatment centers in Orange County.[24] This facility provides long-term care for mentally ill patients throughout Orange County. Royale is a secure facility. As such, patients are insulated and isolated from the outside world while they are under treatment. Although there are scheduled programs, workshops, and other events meant to provide activities and stimulation for the patients, the center has very few, if any, faith-based activities. This is the driver for developing a mental illness ministry at Royale.

This facility has three residential halls. Residents are placed into one of the buildings depending on the state and condition of the individual resident. Each hall operates independently with its own schedule, programs, and activities.

Having personal experience interacting with Royale as a parent of a resident, it is very apparent I have seen clearly that additional activities and programs may be beneficial. For example, currently, there are very few, if any, opportunities for a resident to engage in spirituality- related activities. That said, additional planning, resources, and efforts to bring faith-based programs to this facility are warranted. This gap presents opportunities for churches to engage. Further discussions on how churches can engage will be discussed below in the review of related literature.

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[24] Royale Therapeutic Residential Center, 1030 W. Warner Ave., Santa Ana, CA 92707. Website: "The Path to Recovery and Wellness," RTRC, accessed April 25, 2020, http://royaletrc.com/.

This overview intends to offer an assessment of the current mental illness crisis in Orange County, California. During this review, a few gaps were identified. Mainly, there is a mental illness crisis in Orange County. Further, faith organizations similar to SOTH may not be aware or equipped to contribute to solving this crisis. Lastly, mental health facilities such as Royale do not provide sufficient opportunities for spiritual formation. The next section provides a review of related literature in the field of faith and mental illness. This assessment offers insights into how faith communities currently view mental illness. Additionally, it provides suggestions on ways churches can reach out to the mentally ill.

PART TWO

THEOLOGICAL REFLECTION

CHAPTER TWO:
REVIEW OF RELATED LITERATURE

This review of related literature will focus on five areas. The first pertains to

mental illness ministries viewed from several perspectives. The second is a review of the

relationships between faith-based communities and health care for the mentally ill. The

third is a review of churches as a part of the solution. The fourth is a review of Jesus

Christ, the healer. Finally, there is an assessment and a discussion on taking church to the

mentally ill in mental health facilities.

This exercise has provided an opportunity to develop an understanding and

appreciation for faith and mental illness. Additionally, it has provided an opportunity to

develop a model for conducting worship and praise at the Royale facility.


**Mental Illness Ministries**

Faith and mental illness have been intertwined since the beginning of documented

history. This section is a historical review of faith and mental illness. It is meant to

illustrate mental illness experienced among the faithful and provide insight into the

perception of mental illness in church history. This review is also helpful in developing a

framework to further this project.

God has used people with mental illness for his glory and has instructed those

who are faithful to respect and care for those who are mentally ill.[1] For example, Moses,

David, Jonah, Elijah, and others in the Old Testament exhibited traits of mental illness

such as depression and suicidal tendencies. Jesus came to teach, preach, and heal.

Healing includes psychological illnesses. Paul instructed the faithful who are strong to be

gentle with the weak, including those with emotional and mental illnesses.

According to Dwight Carlson, God's people who had mental illnesses have been

documented since the Old Testament times. Moses, David, Elijah, Job, Jonah, and many

others suffered from some form of mental illness. Some of them neared the point of

suicide because of their pain and suffering (Numbers 11, Psalms, 1 Kings 19, Job 3, and

Lamentations 1-5).[2] Yet, these servants of God were able to overcome their mental

illnesses and faithfully serve God. There are also documented cases of theologians

throughout history who have suffered from mental illness. J.B. Phillips suffered from

psychological disturbances and dark depression. He called it "the dark night of the soul."

Phillips wrote, "It is truly a devastating thing … to be ill in your innermost spirit."[3]

During Phillips's worst times, God seemed remote and unapproachable. Martin Luther

suffered from depression to the point at which he had serious doubts and emotional

distress. Charles Spurgeon suffered from a depression that had tormented him since

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[1] Dwight L Carlson, *Why Do Christians Shoot Their Wounded? Helping (Not Hurting) Those with Emotional Difficultie*s (Downers Grove, IL: Intervarsity Press,1994), 38-43.

[2] Ibid., 40-43.

[3] Ibid., 39.

childhood. He wrote: "I am the subject of depression of spirit so fearful that I hope none of you ever get to such extremes of wretchedness as I go through."[4]

According to Harold Koenig,[5] before the Middle Ages, someone with a mental illness was considered to have specialized skills such as communicating with the spiritual world. Such persons were highly regarded and respected in society. As civilization advanced, severe mental illness was thought to be disordered physiological conditions. Fifth-century Greeks thought hallucinations, delusions, or unusual mental excitement were due to an imbalance of the four humors and not the work of gods or spirits. Mental illness was called a sacred disease in the Hippocratic tradition. Greco-Roman law provided for the care of the mentally ill largely by secluding them to keep them from harming themselves and others. However, care for the mentally ill was generally considered a family responsibility. In severe cases, the person with mental illness could be restrained at home or be allowed to wander the streets.

In Greek and Roman times, mental illness was no longer seen as a special gift. A person with mental illness was viewed as strange, deranged, and fearsome. One popular belief was that evil spirits were causing the illness and might fly out and possess others around the person with the mental illness. As a result, those with mental illnesses were avoided. If a person with mental illness did not have family members willing to care for them, a caretaker might be assigned, or the person might be held in jail.[6] The early

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[4] Ibid.

[5] Harold Koenig, *Faith and Mental Health: Religious Resources for Healing* (West Conshohocken, PA: Templeton Foundation Press, 2005), 17-18.

[6] Ibid., 18.

Christian East had three views on mental illness. Jean-Claude Larchet describes these three views as mental illness due to somatic problems, of demonic origins, or of spiritual origins.[7]

As noted, mental illness is not a new phenomenon. Furthermore, faith has played a part in understanding and caring for the mentally ill. The people of God were not immune to mental illness historically, nor are they immune in current times.

Dennis Coday calls mental illness the "no casserole" disease.[8] When someone from church has a physical ailment that requires hospitalization, the church can quickly mobilize and provide tangible support such as meals to the family, house cleaning, and transportation for school-age children. Someone from church brings a "casserole." However, when the church discovers someone has a mentally ill, the church seldom brings casseroles. Coday suggests the reason this phenomenon takes place is due to the stigma associated with mental illness. This does not mean the church is not willing to respond. Instead, the church may not know how to respond appropriately. For Donald Capps, the majority of faith leaders are not prepared to adequately address mental health-related issues. This is primarily due to the lack of mental health training at all levels from seminaries to local lay leadership training.  Capps suggests this is a significant gap in

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[7] Jean-Claude Larchet, *Mental Disorder and Spiritual Healing: Teaching from the Early Christian East* (San Rafael, CA: Angelico Press, 1994), 8-11.

[8] D. Coday, "When You're Mentally Ill, No One Brings You a Casserole*," National Catholic Reporter* 45, no. 26, (2009): 1, https://fuller.idm.oclc.org/login?url=https://search-proquest-com.fuller.idm.oclc.org/docview/215300451?accountid=11008.

many churches and provides seven reasons why ministers need to be aware of mental

illness:

> Some of the persons you will be working with are suffering from a mental illness:
>
> 1. People who develop serious mental illness will typically exhibit mild signs of depression and anxiety in their teens and early twenties. Pastors working with youth groups and young adults may be aware of these behaviors as these pastors may know the individual more intimately than their parents;
> 2. Some ministers may be suffering from some form of mental illness. Does ministry as a profession select persons who are susceptible to a mental illness or does ministry create the condition for a mental illness to occur?
> 3. Christian denominations and types of mental disorder have some correlation. This does not mean the denomination of the church caused the mental illness. It can be that certain denominations are attractive to those who may have a predisposition to a particular mental illness based on the denomination's ability to serve their specific needs. From this perspective, the church may serve as a preventative as well as a rehabilitative function;
> 4. Some people may be predisposed to mental illness. Yet not all who are predisposed will become mentally ill. The church and the minister may play an important role in prevention of mental illness;
> 5. A part of a minster's training should be a period of time serving in a mental health facility. Chaplaincy began in a state mental hospital.
> 6. Ministers can play a very important role as advocates for the mentally ill and their families. [9]

Clark Aist suggests that the significance of religion and spirituality is being

recognized and is occupying a place of more relevance in the practice of psychiatry. Aist

offers several reasons for this shift towards the acceptance of religion and spirituality.

First, culture is a significant component of human healing.[10] As such, religious beliefs

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[9] D. Capps, "The Minister and Mental Illness," *Pastoral Psychology* 63, no. 1, (2014): 14-16, http://dx.doi.org.fuller.idm.oclc.org/10.1007/s11089-012-0499-za

[10] Clark S. Aist, "The Recovery of Religious and Spiritual Significance in American Psychiatry," *Journal of Religion and Health* 51 (2012): 618, EBSCOhost.

and spiritual practices are inextricably linked to cultures.[11] Culture cannot be separated

from religion. As such, culture-based spirituality should be considered a component of

competent psychiatric care. The second point is the creative power of ritualized

dependency.[12] For Aist, the mentally ill may benefit from being in ritualized settings such

as the church where a sense of belonging and a connection with the divine can contribute

to the well-being of people. The third is the psychic function of belief can serve as the

"gap filler" for what is not yet understood.[13] Fourth, Aist suggests there is a

neurobiological foundation for faith and spirituality. The biology of the brain is related to

faith-driven experiences.[14] Specifically, experience changes the brain, meditation

strengthens memory and reduces stress, and deep mystical experiences have neuro-

biological correlations. Aist's research asked participants, "'What is the most important

support for your recovery and life?' Answer: 'God.'"[15]

The fifth point is the relevance of the recovery narrative with four points.[16]  They are

(1) a spiritually-oriented core identity, (2) new metaphors for understanding one's life

story, (3) an openness to guilt and receiving forgiveness, and (4) recognition of a call for

mission.

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[11] Ibid., 619.

[12] Ibid., 620.

[13] Ibid., 623.

[14] Ibid., 624.

[15] Ibid., 626.

[16] Ibid., 627.

To summarize, faith and mental illness have been intertwined since the early days of Christianity. Scripture describes humans who had mental illness and how God used them for his purpose. Further, Christians are not immune to this illness, and many noted theologians have suffered from mental illness. Coday, Capps, and Aist all suggest the church, faith, and spirituality can play a significant role in an overall care program for the mentally ill. These researchers and many others have made significant contributions toward understanding the role of faith and mental illness. This said, there should be research into how churches can engage could further expand the Christian response. The knowledge gained from these researchers will serve as the baseline for developing a meaningful worship ministry to the mentally ill. The next section is a discussion of faith and health care for the mentally ill.

## Faith and Health Care for the Mentally Ill

Mark DeKraai, Denise J. Bulling, Nancy C. Shank, and Alan, J. Tomkins provide insight into how faith-based organizations can contribute to the behavioral health care system. For DeKraai et al., faith communities have inherent resources that can enhance the reach and effectiveness of the mental health system.[17] Effective partnering of the faith community and the behavioral health community can lead to several benefits. Incorporating faith can help with mental illness and substance abuse. Further, faith

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[17] Mark B. DeKraai, Denise J. Bulling, Shank, and Alan, J. Tomkins, "Faith-Based Organization System of Behavioral Health Care," *Journal of Psychology and Theology* 39, no. 3 (2011): 255, EBSCOhost.

communities can fill the gaps in the behavioral health communities.[18] DeKraai et al.

describe an integrated behavioral health model where faith plays an equal role with the

other components of secular provider organizations, support service agencies, and

public/private funding and regulatory agencies.[19] Figure 2.1 is an illustration of this

model.

Figure 2.1. Integrated Behavioral Health Model that Includes Faith Organizations
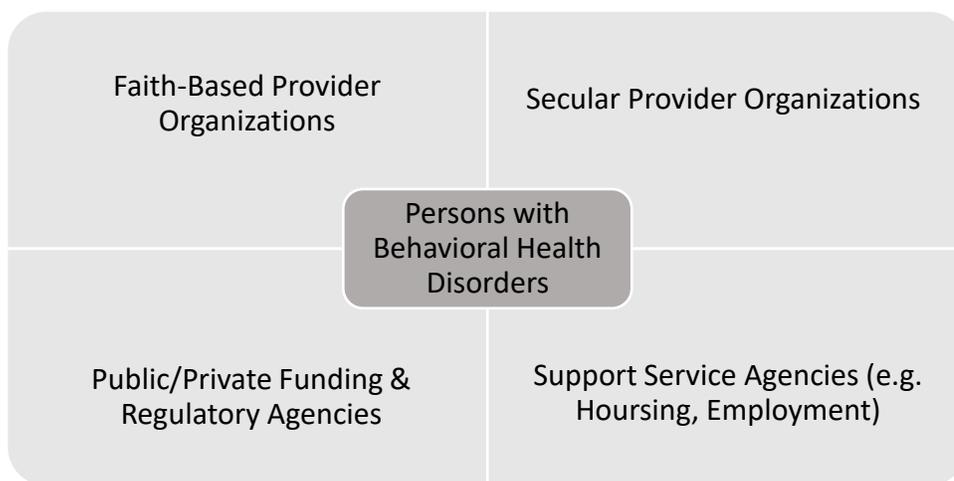


Sylvia Mohr states that spirituality and religiousness are resources for finding

meaning and hope in suffering and have been identified as crucial components in the

process of psychological recovery.[20] However, Mohr also cautions that religion may also

be associated with psychopathology, suffering, and non-adherence with psychiatric

treatment. Mohr recommends an approach where spirituality and religiousness are

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[18] Ibid., 256.

[19] Ibid., 257.

[20] S. Mohr, "Integration of Spirituality and Religion in the Care of Patients with Severe Mental Disorders, *Religions* 2, no. 4, (2011): 549, http://dx.doi.org.fuller.idm.oclc.org/10.3390/rel2040549.

components of recovery for those with severe mental disorders with consideration for the cultural context of the patient and the caregiver in psychiatric care. In other words, spirituality and religiousness is not a one-size-fits-all factor. Its application should be considered on a case by case basis.

Jim Banta and O. Mckinney's study on the length of stay in faith-based hospitals suggests a holistic approach where spiritual dimensions that are incorporated into an open and inclusive treatment plan can contribute to lowering the term of stay for psychiatric inpatients. Banta also suggests that further research is needed to understand the reason faith-based inpatient psychiatric care contributes to shorter-term stays. Areas for further research can be religious affiliations, the spiritual status of the patient, and area-based measures of religious affiliations.[21]

Steve Sullivan, J. M. Pyne, A. M. Cheney, J. Hunt, T. F. Haynes, and G. Sullivan describe the current tension between faith organizations and the medical profession and offer several observations.[22] From Sullivan et al.'s perspective, there is a lack of trust between clergy and clinicians. Because of stigma the contribution between the clergy and mental health clinicians is undervalued. There is a lack of knowledge on how clergy and clinicians can collaborate.[23] To illustrate this point, Sullivan et al. describe three models

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[21] J. E. Banta and O. Mckinney, "Faith-Based Hospitals and Variation in Psychiatric Inpatient Length of Stay in California, 2002-2011," *Journal of Religion and Health* 55 (2016): 800, http://dx.doi.org.fuller.idm.oclc.org/10.1007/s10943-015-0175-6.

[22] S. Sullivan, J. M. Pyne, A. M. Cheney,  J. Hunt, T. F. Haynes, and G. Sullivan, "The Pew Versus the Couch: Relationship between Mental Health and Faith Communities and Lessons Learned from a VA/Clergy Partnership Project," *Journal of Religion and Health* 53, no. 4 (2014): 1267, https://dx.doi.org.fuller.idm.oclc.org/10.1007/s10943-013-9731-0.

[23] Ibid., 1275.

of mental illness and spirituality. The first considers mental illnesses to be spiritual

problems with spiritual solutions. According to this perspective, all mental illness-related

issues are spiritually driven. Psychological issues are merely manifestations of demon

possession, evil spirits, or the work of the devil.[24] Healing can only come from faith and

prayer. This approach is ethnically-, culturally-, and geographically-based. For example,

mental illnesses are perceived as spiritual problems in Latino faith communities, and

cures may involve exorcism and faith healing. African Americans in Southern states

have a similar perception and believe mental illness may be caused by the devil or a poor

relationship with God. As such, healing through faith, prayer, and involvement in the

church community is generally practiced.[25]

The second model holds that mental illness are mental problems with spiritual

solutions. According to this perspective, mental illness is considered real and primarily

requires spiritual solutions. This model is widely accepted in Christian communities in

the South. This approach suggests mental illness may result from loss of faith, lack of

prayer, stress, and being distant from the Lord as opposed to being demon-possessed.

Those who subscribe to this model would be more likely to consider Christian counseling

and would be willing to accept the benefits from professional treatment from a biblical

perspective.

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[24] Ibid., 1276.

[25] Ibid., 1277.

The third model is described as "Mental Illness, Spiritual and Mental Solutions."[26] In this model, mental illnesses are both mental and spiritual issues. As such, a person can derive benefits from both medical treatment and spiritual healing. Biopsychosocial risk factors may cause psychological problems. Psychotherapy and other mental health services may be combined with spiritual practices. Typically, the stigma associated with mental illness is lower in churches that hold this view. People from this camp would likely consider seeking treatment from both Christian and secular resources. Churches should be working alongside mental health providers to increase the mental and spiritual health of the churches and the community they serve.

These three models illustrate the divide between faith organizations and mental health institutions. For instance, those who subscribe to the first model see mental illness as the work of the devil and may not see any benefits from medicines for healing mental illness and may even distrust those from the medical community. Those who subscribe to the second model would differ from those supporting the first model but would also question the benefits of treatments from the secular perspective. Lastly, those who align with the third model may be at odds with those supporting the first two models. Obstacles, barriers, and hesitancies can be present under these scenarios. Despite these and other barriers, mental health caregivers are welcoming engagements and partnerships with the faith community. In fact, many clinicians are eager to seek out ways to collaborate with faith communities to better support their clients, where faith is vital to

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[26] Ibid.

the patient.[27] To facilitate this project, I employ model three as it appears to be comprehensive and inclusive in nature. In this mental illness treatment model, medicine, spirituality, and other factors can all be considered and can co-mingle meaningfully.

Harold Koenig and D. B. Larson also describe the negative and positive associations between faith and mental illness.[28] Faith can contribute negatively to individuals by levying additional stressors, which can lead to symptoms such as depression and anxiety. Studies in this field have indicated people of faith may be more likely to develop mental and emotional issues. Faith can also be positively associated relative to well-being and life satisfaction. Positive attributes would be hope, optimism, purpose, and meaning. These types of correlations can be seen in patients with affective disorders, substance abuse, and other mental ailments. According to Koenig and Larson, the negative impacts are relatively low compared with the positive associations. Nearly 80 percent of studies relative to faith and mental illness support this finding. Koenig and Larson suggest that spirituality and the need for religiousness are widely prevalent among psychiatric patients.[29] Ironically, clergy and chaplains have had limited access to this population.

David Bergamo and Dawn White also support the significance of faith and spirituality in the lives of the mentally ill. Unfortunately, their research suggests that only a small percentage (less than ten percent) of participants had discussions about the need

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[27] Ibid., 1278.

[28] H. Koenig and D. B. Larson, "Religion and Mental Health: Evidence for an Association," *International Review of Psychiatry* 13 (2001): 70-72, EBSCOhost.

[29] Ibid., 73.

to consider faith and spirituality in their treatment regime. These two researchers also concluded that faith and spirituality have both positive and negative associations. This applies to both the patients and health care professionals. The lack of frequency of spiritual discussions leads to misunderstandings between the patient and the clinician on the need for faith and spirituality as a part of a person's overall well-being, leaving an unclear message on the benefits of faith and spirituality for both the patient and clinicians.[30]  In many instances, the patient's feelings about faith and spirituality may be neglected. These are missed opportunities, especially from a holistic approach in which the physical, social, emotional, and spiritual needs are considered together as a comprehensive treatment plan.[31]

The studies of DeKraai et al., Mohr, Banta, and McKinney, Sullivan et al., Koenig and Larson, and Bergamo and White indicate ways spirituality practices can be beneficial to mentally ill patients in treatment. The challenge, then, is the lack of understanding of the value faith and medicine can create for patients. There seems to be a need to develop models where faith and spirituality hold equal footing and are looked upon as complementary approaches as opposed to counteractive methods. One of the goals of the present project is to seek out such opportunities for integrating faith and medicine. The next section is a discussion on the church as a part of a solution where treatment programs integrate faith into medicine.

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[30] D. Bergamo and D. White, "Frequency of Faith and Spirituality Discussion in Health Care," *Journal of Religion and Health* 55 (2016): 619.

[31] Ibid., 621.

## The Church as Part of the Solution

The literature from faith, spirituality, and mental health suggest active involvement from churches can be a significant component of an overall comprehensive treatment program and may be beneficial to the patients, clinicians, and other stakeholders. The church can and should be integrated into an inclusive model, in which all possible and plausible alternatives are considered. This model would include an understanding of Jesus the healer, the importance of ministries for the mentally ill, equipping the church for mental illness ministries, and developing a framework for the church to employ mental illness ministries. Amelia Roberts-Lewis and T. D. Armstrong provide insights into how the church can move towards social action. Faith-based social action is defined as the intention and effort of the church to create positive changes in the lives of persons, families, and communities.[32] While many churches have made strong commitments to serving the marginalized, the vast majority of churches encounter a variety of barriers to taking social action. Some of these barriers are theological in nature while other boundaries are due to differences regarding ecclesiology or on how a church understands itself to be church. The degree to which a church may choose to engage in a social issue is closely associated with the identification of the social problem itself. In other words, a church's response to homelessness may be related to whether homelessness is viewed as is a moral failure or as a societal failure to care for those most

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[32] A. Roberts-Lewis and T. D. Armstrong, "Moving the Church to Social Action," *Social Work and Christianity* 37, no. 2 (2010): 117, https://fuller.idm.oclc.org/login?url=https://search-proquest com.fuller.idm.oclc.org/docview/517881229?accountid=11008.

vulnerable.[33]  Robert-Lewis and Armstrong quote H. Richard Niebuhr: "How does the church engage the broader culture? Do we work against, of, above, in paradox to, or in transformation of the culture in which we find ourselves?"[34]

Churches currently provide services directly to the congregants, to the community, and in some cases to both. Services can be for long term, short term, or in cases of emergencies. Although many of these services are in place in many churches, there is still a gap between the need and the level of support. This is mainly due to the relatively low level of intensity of the services churches provide.[35]  Robert-Lewis and Armstrong suggest that a Christian social work model may be a way to fill this gap.  This model consists of the following:

1.  Christian social workers can be service brokers between health care agencies and faith communities.
2.  Christian social workers can serve as consultants to local churches advising them critical support needed in the community and assisting the church on ways to support the need.
3.  Christian social workers can provide necessary training to enable churches to better prepare serve the needs of the community.
4.  Christian social workers can be the advocate who brings about change for those who are not able to speak for themselves such as the mentally ill.
5.  Christian social workers can facilitate and coordinate psychotherapy to their fellow church members.
6.  Christian social workers can assist churches with establishing pastoral care and specific ministries to support the needs of the community.[36]

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[33] Ibid., 118.

[34] Ibid.

[35] Ibid., 120.

[36] Ibid., 121-123.

Janelle Stanley offers a contemporary Quaker pastoral care model for the mentally ill. In this model, there is a recognition of the presence of God within every person. This is the principal premise of the historical as well as the modern psychological and pastoral care model in the Quaker tradition. Recognizing this sense of kinship with God instead of being distant from God is a necessity for understanding the psychotic mind.[37] From the Quaker perspective, mental illness may not be understandable and may be difficult to discern, but caregivers enter each interaction with a deep belief that God is present and is discernable. Further, God's presence manifests in many different ways and God's way may not be called crazy. People come to the presence of God as they are with their psychological baggage. Caregivers are to promote deep and compassionate spiritual listening.

Stanley introduces Jennifer Elam, a licensed psychologist and a Quaker, who illustrates this model. Those who suffer from mental illness often come to forks in the road. One of the paths leads to alienation, isolation, and disconnectedness. On this path, the person cannot reach God or others and cannot get out of this state. The other path is a movement towards God—toward a sense of purpose and knowing God is present no matter what. When confronted with these two options, the mentally ill person may not recognize the best choice and may take the path on which he or she cannot connect with God and others. Outwardly, psychotic, criminal, addiction, and other unsavory behaviors are exhibited. Inwardly, the person is living in alienation. Elam argues there is a need to

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[37] J. Stanley, "Night and Inner Light: A Quaker Model of Pastoral Care for the Mentally Ill," *Journal of Religion and Health* 49 (2010): 554, EBSCOhost.

help patients access divine guidance described as a strong sense of one's own unique God-given identity and know they are connected with God.[38]

Coday suggests that churches can be an agent to remove the stigma of mental illness. This can be done through very simple and already-recognized church initiatives. Simple gestures such as notices on bulletin boards about mental illness, prayers for mental illness, occasional preaching about mental illness, and providing space to enable mental illness ministries can be the starting points for creating a viable and sustainable mental illness ministry.[39]

R. Foster-Jones, L. Dietzfelbingher, D. Stedman, and P. Richmond's study suggests spirituality as an agent of recovery for those with severe mental illnesses.[40] Spirituality as a dimension of the quality of life and well-being has recently begun to be more valued with person-centered treatment approaches to mental health in the United Kingdom. However, despite the evidence pointing to the significance of spirituality in a well-rounded treatment approach, policies, procedures, and practices may limit the benefits of spiritual well-being.[41] This study was conducted with patients in treatment at mental health facilities in group settings. Three themes emerged from this research relative to spirituality and mental health. The first was the religious aspects of the

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[38] Ibid., 555.

[39] D. Coday, "When You're Mentally Ill, No One Brings You a Casserole*," National Catholic Reporter* 45, no. 26, (2009): 1, EBSCOhost.

[40] R. Foster-Jones, L. Dietzfelbingher, D. Stedman, and P. Richmond, "Including the 'Spirit' within Mental Health Care in the UK, from the Experience of People with Mental Health Problems," *Journal of Religion and Health* 57 (2018): 385, EBSCOhost.

[41] Ibid., 386.

group.[42] A small group at a mental health facility can be a substitute for a church and is a gentler approach to church. Many of the participants enjoyed being a part of a group. The second was the effect of settling spiritual confusion. In a group setting, members had the opportunity to discuss personal matters, including resolving questions about faith and spirituality. It was an opportunity to seek the truth.[43] The third was assisting group members with the recovery process. Being in a spiritual group made the members feel better and it provided structure to the week. Three recommendations were made at the conclusion:

1. Caring for the spirit groups should be more common within psychiatric services.
2. Psychiatric staff should attend the groups, so they can understand the spiritual dimension to people's mental illness.
3. Continuity of spiritual care once individuals have been discharged from treatment should be accessible.[44]

In this section, Robert-Lewis and Armstrong provided insights into barriers for churches to enter into ministries supporting the marginalized. This is especially true for churches interested in mental illness ministries. It does not mean churches are not able to undertake these ministries. For example, Stanley offered a Quaker model of pastoral care for the mentally ill. Coday and Foster-Jones et al. provide models for how churches can engage in mental health ministries. The limiting factor seems to be a clear understanding of the reasons for the various barriers and how church can break into meaningful ministries for the mentally ill. For instance, many churches are willing to engage in

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[42] Ibid., 399.

[43] Ibid., 400.

[44] Ibid., 403.

ministries for the homeless. However, many who are homeless have mental illnesses. Ironically, many churches are not willing to engage in ministries for the mentally ill. The present project can potentially contribute toward understanding the reluctance to engage in mental health ministries.

## Taking Church to the Mentally Ill at Mental Health Facilities

To develop a model for mental health ministries at mental health facilities, I reviewed several spiritual models used by researchers in this field. This review included the works of Nathan Carlin,[45] Nancy C. Kehoe,[46] Ana Wong-McDonald,[47] Nadine Revheim, and William M Greenberg,[48] Marc Galanter, Helen Dermatis, Nancy Talbot, Caitlin McMahon, and Mary Jane Alexander,[49] Russell E. Phillips, Rebecca Lakin, and

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[45] Nathan Carlin, "Reflections for Clinical Pastoral Education Students in Psychiatric Settings," *Journal of Religion and Health* 57, no. 2, (2018): 523-537, http://dx.doi.org.fuller.idm.oclc.org/10.1007/s10943-017-0450-9.

[46] Nancy C. Kehoe, "Spirituality Groups in Serious Mental Illness," *Southern Medical Journal* 100, no. 6 (2007): 647-648, EBSCOhost.

[47] Ana Wong-McDonald, "Spirituality and Psychosocial Rehabilitation: Empowering Persons with Serious Psychiatric Disabilities at an Inner-City Community Program," *Psychiatric Rehabilitation Journal* 30, no. 4 (2007): 295-300, EBSCOhost.

[48] Nadine Revheim and William M. Greenberg. "Spirituality Matters: Creating a Time and Place for Hope," *Psychiatric Rehabilitation Journal* 30, no. 4 (2007): 307-310, EBSCOhost.

[49] Marc Galanter, Helen Dermatis, Nancy Talbot, Caitlin McMahon, and Mary Jane Alexander, "Introducing Spirituality into Psychiatric Care," *Journal of Religion and Health* 50 (2011): 81-91, EBSCOhost.

Kenneth I. Paragament,[50] and Amy G. Weisman de Mamani, Naomi Tuchman, and

Eugenio A. Duarte.[51]

Nathan Carlin facilitated spiritual groups for the mentally ill. He developed a

step-by-step program for ministering to the mentally ill. His plan includes specific

liturgy, tools, techniques, and lessons learned.[52] Nancy Kehoe describes her twenty-five

years of experience and lessons learned from conducting therapy groups with severe

mental illness focusing on spiritual beliefs and values.[53] Some of the significant lessons

learned from her discussion groups included the stipulations that each group member

must be able to respect and tolerate religious differences of others in the group, no

member can impose their beliefs on other members, and no members is a judge of other

members. Ana Wong-McDonald advocates incorporating spirituality into a rehabilitation

program that empowers persons with severe psychiatric disabilities. She concludes that

those who engage in spirituality achieve their goals at a much higher rate than those who

do not participate in spiritual activities.[54] Nadine Revheim and William M. Greenberg

describe the contents of their spirituality sessions focused on storytelling as a way to

engage the residents with their sense of abandonment, anger, and disappointment in their

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[50] Russell E. Phillips III, Rebecca Lakin, and Kenneth I. Pargament. "Brief Report: Development and Implementation of a Spiritual Issues Psychoeducational Group for Those with Serious Mental Illness," *Community Mental Health Journal* 38, no. 6 (2002): 487-494, EBSCOhost.

[51] Amy G. Weisman de Mamani, Naomi Tuchman, and Eugenio Duarte, "Incorporating Religion/Spirituality into Treatment for Serious Mental Illness," *Cognitive and Behavioral Practice* 17 (2010): 348-357, ESBSCOhost.

[52] Carlin, "Reflections for Clinical Pastoral Education Students," 533.

[53] Kehoe, "Spirituality Groups," 647.

[54] Wong-McDonald, "Spirituality and Psychosocial Rehabilitation," 298.

spiritual life.[55] Galanter et al. developed a spirituality program and introduced it into a

psychiatric care center. Their method references the Alcoholics Anonymous (AA) model

as a baseline.[56] Phillips et al. implemented a spiritual group for those with mental illness.

Their program included a variety of spiritual resources, including prayer, religious

literature, prayer groups, going to religious services, journaling, spiritual music, burning

candles, artwork, and socializing with friends.[57] Weisman et al. incorporated a spiritual

component into a Culturally-Informed Therapy (CIT) program for schizophrenia. They

designed the religious coping module of the CIT to assist with integrating spirituality into

the treatment of severe mental illness. Handouts such as "Exploring Your Spirituality"

were references and resources for their group sessions.[58]

Table 2.1 is a list of the works of each of these researchers and their specific focus

areas. The first column identifies the researchers. The second column describes the

program. The third column specifies the setting of the spiritual group. The fourth column

describes the content of the group, and the last column illustrates the spiritual practice.

Table 2.1. List of Research on Spirituality and Mental Health

| Researcher | Program | Setting | Content | Spiritual Practice |
|---|---|---|---|---|
| Carlin (2018) | Spiritual Group to psychiatric settings | Weekly ongoing group | Worship and praise | Music, prayer, and Scriptural readings |

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[55] Revheim and Greenberg, "Spirituality Matters," 309.

[56] Galanter et al., "Introducing Spirituality into Psychiatric Care," 83.

[57] Phillips et al. "Brief Report," 490.

[58] Weisman et al., "Incorporating Religion/Spirituality into Treatment, 354.

| Kehoe (2007) | Beliefs and Values | Weekly ongoing group | Discussion on belief and values | None |
|---|---|---|---|---|
| Wong-McDonald (2007) | Spirituality Group | Weekly ongoing group | Discussion on spirituality and recovery | None |
| Revheim and Greenberg (2007) | Spirituality Matters Group | Weekly ongoing group | Focus on recovery | Prayer and storytelling |
| Galanter et al. (2011) | Spiritual Group | Weekly ongoing group | Focus on coping with mental illness | None |
| Phillips and Lakin (2002) | Spiritual Issues Psychoeducational Group | Seven sessions | Psycho-education | Prayer |
| Weisman et al. (2010) | Spiritual Coping Group | Three sessions | Psycho-education | None |

From this collection of researchers, I selected various aspects that were

appropriate to further my project as not all of these practices were applicable. For

example, I incorporated some of Kehoe's comments for facilitating group Scriptural

discussions. I also included the cultural components from Weisman et al., and I included

the concept of making spiritual resources available to the residents from Phillips et al.  Of

the seven cases, only three incorporated some form of group prayer.  Interestingly,

Carlin's program is the only case where music, praise, and worship are a part of spiritual

practice. It appears that most research on faith and mental illness focuses on how

spirituality can be a component of the overall treatment program as opposed to offering

specific opportunities for spiritual formation. To focus on spiritual formation, the work of

Carlin will serve as the primary source model, and the works of Kehoe, Weisman et al.,

and Phillips et al. will serve as supporting resources in the development of this project.

Carlin provides a reflection of his experience working in psychiatric settings as a part of his clinical pastoral education.[59] As a student of Donald Capps, Carlin highlights three key insights from Capps on mental illness and discusses how he applied them to his ministry with persons with mental illness. The three insights are fragile connection, social phobia, and understanding psychosis. Fragile connections refer to the lack of mental illness awareness many seminarians have due to the lack of mental illness training at many seminaries. Social phobia refers to the reluctance to share about mental illness for fear of disassociation and isolation. The fear of self-revelation can impact employment opportunities, career advancements, and the ability to make and keep friends. Understanding psychosis refers to comprehension and appreciation by the sufferers, families, and friends. In general, people with mental illness do better when they are understood.

These three insights form the following three points. First, social support can, to a great extent, influence the well-being of persons with mental illness.[60] Second, while mental illness presents authentic challenges, it presents opportunities as well.[61] Lastly, reading is therapeutic. Being informed can provide avenues for understanding the healing process.

With these three tenets in mind, Carlin ventured into his mental health ministry and offered the following reflection from his experiences applying them. Carlin found

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[59] Carlin, "Reflections for Clinical Pastoral Education Students," 524.

[60] Ibid., 528.

[61] Ibid., 530.

that patients especially enjoyed listening to and singing hymns. He selected hymns and praise music appropriate to the demographics of the mental health facility. Carlin also did not preach at these worship services because he did not believe sermons were important for patients in a mental health facility setting. Instead, Carlin reflected on a lectionary passage with the group. Carlin asked for volunteers to read the passage and then let the group discuss the passage. The discussion closed with a summary and mirroring back, focusing on what the group members affirmed about God and themselves. Sharing joys and concerns is also a good group activity. For instance, one way to engage the group in sharing of blessings is with this invitation: "It is a time to share what you are thankful for and what individuals in the group may be thankful for."[62] Carlin also provided a sample structure for conducting worship at mental health facilities The components are
 (1) Moment of silence, (2) Opening sentences, (3) Call to worship, (4) Hymn, (5) Call to confession, (6) Prayer of confession, (7) Declaration of pardon, (8) Joys and concerns, (9) Hymn, (10) Pastoral prayer and the Lord's Prayer, (11) Scripture reading and group reflections, (12) Hymn, and (13) Benediction.[63]

Carlin concluded his work with three lessons for those interested in mental illness ministries: (1) show patients that they matter by taking worship seriously, (2) show patients that you trust them, (3) tell patients that God loves them verbally and nonverbally.[64]

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[62] Ibid., 532.

[63] Ibid., 533.

[64] Ibid., 534-535.

For DeKraai et al., ministry to the homeless and mentally ill can be a model for going to and serving the marginalized in society.[65] The reason is that if those who minister to people with mental illnesses can understand the intricacies and idiosyncrasies of developing viable ministries for them, including all of the ministries' limitations such as the human conditions, stigma, and side effects of mental illness, those interested in venturing into other similar ministries can develop these ministries using the lessons learned from mental illness ministries. For the proposed project, Carlin's approach to engaging with the mentally ill serves as the baseline model and will be customized and modified to meet the needs of the Royale Therapeutic Residential Center.

This review of relevant literature provided several significant revelations towards the understanding of faith and mental illness. From a Christian perspective, mental illness has been recognized as an illness that can be healed. Jesus had compassion for humans and showed mercy by physically healing people and teaching his disciples to treat illnesses. Healing illness is not the same as curing a disease. A part of healing is to accept the disease in the social context and provide paths to restore those who are suffering from a disease back into society by removing the stigma, shame, isolation, and rejection associated with the disease. Christian healing ministries should be aware of the healing power Jesus taught and know that ordinary humans are capable of providing healing to those in need. Going to the marginalized with unconditional love is a means of providing healing.

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[65] DeKraai et al., "Faith-Based Organization System," 257.

CHAPTER THREE:
JESUS CHRIST THE HEALER AND MINISTRIES TO
THOSE WHO ARE IMPACTED BY MENTAL ILLNESS

> Word got around the entire Roman province of Syria. People brought anybody
> with an ailment, whether mental, emotional, or physical. Jesus healed them, one
> and all (Mt 4:24).[1]

In Mt 4:24, Jesus' ability to teach, preach, and heal is evident. This project

focuses on Christ's ability to heal. In *The Message* version of Mt 4:24, Eugene Peterson

describes Jesus treating physical, emotional, and mental ailments. For this project, the

scope of Jesus' healing is focused solely on emotional and psychological ailments.

Among a variety of Bible versions, *The Message* Bible seems to be the only version that

specifically identifies Jesus' healing of emotional and mental illnesses. For instance, the

New Revised Standard Version (NRSV) describes the healings as "demoniacs, epileptics,

and paralytics." The American Standard Version describes Jesus healing the "possessed

with demons, and epileptic, and palsied." The New International Version (NIV) states the

healing as "demon-possessed, those having seizures, and the paralyzed." The New Living

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[1] Eugene H. Peterson, *The Message: The Bible in Contemporary Language* (Colorado Springs, CO: NavPress, 2005), Mt 4:23–24, Logos Bible Software 7.

Translation (NLT) uses the terms "demon-possessed or epileptic or paralyzed." The New King James Version states it as "demon-possessed, epileptics, and paralytics."

For those impacted by emotional problems and mental illness, reading *The Message* version of Mt 4:24 and seeing a direct reference to Jesus healing emotional and mental ailments can bring much-needed hope. To know Jesus can heal sicknesses such as depression, bipolar disorder, anxiety, and schizophrenia may be a source of comfort for those who are suffering from these and other related illnesses. Further, to understand exactly how Jesus heals these types of ailments and to replicate his healing practices in mental health ministries.

To facilitate further investigations, I crafted a model for developing a mental illness ministry, shown in Figure 3.1. In this model, there are three components. The first component serves as the basis for a Christ-centered mental illness ministry. The works of Donald Capps[2] and Richard Culpepper[3] serve as the foundation for the baseline model for a mental illness ministry emulating Jesus Christ, the healer. Capps and Culpepper contribute to an understanding of the significance of reaching out to the marginalized for believers and followers of Jesus Christ. Capps also offers a strong argument for the ways Jesus healed mental illness. The second component has two directives. The first is to understand the significance and the need for mental illness ministries. Jürgen Moltmann's *Crucified God*[4] is the primary source that supports the need for mental illness ministries,

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[2] D. Capps, *Jesus the Village Psychiatrist* (Louisville, KY: Westminster John Knox Press. 2008).

[3] R.A. Culpepper, "Jesus as Healer in the Gospel of Matthew, Part 1: Methodology," *In die Skriflig/ In Luce Verbi,* 50, no. 1 (2016), http://dx.doi.org.fuller.idm.oclc.org/10.4102/ids.v50i1.2115.

[4] Jürgen Moltmann, *The Crucified God*, 40th Anniversary ed. (Minneapolis, MN: Augsburg Press 2015).

especially for those with severe mental illness. The second relates to methods to equip

oneself for a healing ministry for those who are emotionally and mentally broken. The

writings of Henri Nouwen,[5] Jean Vanier,[6] and Richard Beck[7] served as primary

references for identifying the elements of healing and potential components of a mental

illness ministry.  The components of this type of ministry are hospitality, community,

acceptance, forgiveness, accompaniment, belonging, and restoration. The third

component focuses on the framework for mental illness ministries. Using Nathan Carlin's

work in a psychological hospital,[8] I created the framework of the mental illness ministry

for this project. The focus is to understand God's love manifesting as acceptance,

forgiveness, restoration, and a sense of belonging.

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[5] Henri J. M. Nouwen, *Can You Drink the Cup?* 10th Anniversary ed. (Notre Dame, IN: Ave Maria Press, 2006).

[6] Jean Vanier, *Becoming Human* (Toronto, ON: House of Anansi Press, 2008, Kindle.

[7] Richard Beck, *Unclean: Mediation on Purity, Hospitality, and Mortality* (Eugene, OR: Cascade Books, 2011).

[8] Carlin, "Reflections for Clinical Pastoral Education Students," 523-537.

Figure 3:1. Model for Crafting a Mental Illness Ministry
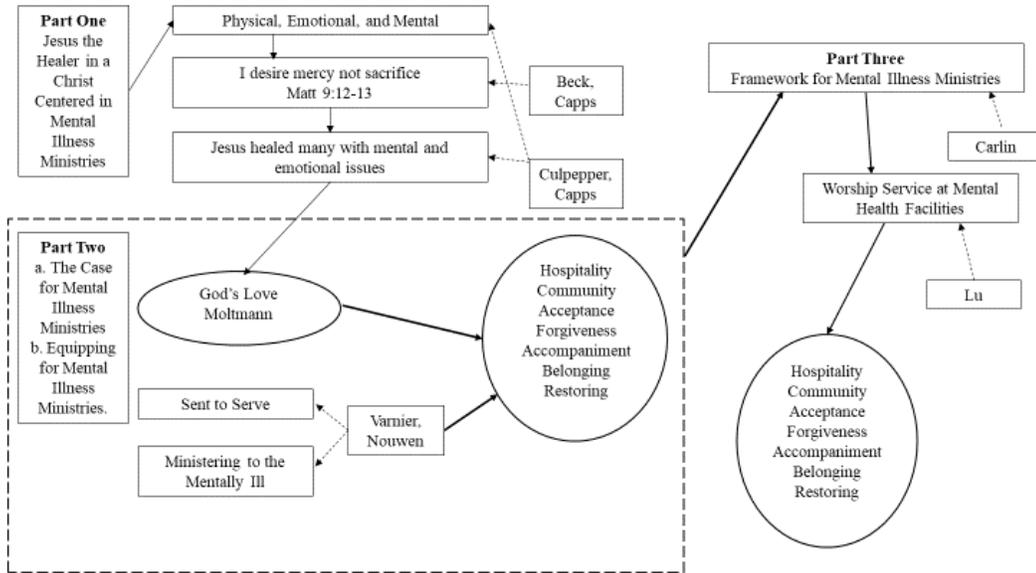


**Jesus Christ the Healer in Christ-Centered Mental Illness Ministries**

This section is a review of Jesus Christ, the healer. Culpepper examines Jesus as a

healer in the Gospel of Matthew. Culpepper attempts to bring "faith/sacred scripture and

science/biomedicine" together into an approach where the healing arts of medicine and

healing from God are both embraced.[9] One of Culpepper's major premises is the

understanding of the implication of culture relative to illness and healing. Illness is

culturally defined, and it includes physical, social, and spiritual dimensions. Healing is

also culturally defined and should be understood more broadly than the typical modern

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[9] Culpepper, "Jesus as Healer," 1.

medical focus on curing a patient's disease.[10] From this comprehensive view, healing can mean regaining physical and spiritual wholeness.

Culpepper focuses specifically on Matthew 8-9 to make his case, referencing Mt 9:12-13, "Those who are well have no need of a physician, but those who are sick. Go and learn what this means, 'I desire mercy, not sacrifice.'" In Mt 9:35, Jesus goes about the cities "curing every disease and every illness," the text explains that he had compassion on the people in v. 36. From these passages, Culpepper suggests that compassion and mercy appear to be the primary impulses for Jesus' healing ministry.[11] Culpepper further supports his claim by the various healing stories in Matthew 8-9. In these stories, Jesus cleanses a leper (Mt 8:1-4), heals a centurion's servant (Mt 8:5-13), heals Peter's mother-in-law and others (Mt 8:14-17), heals the Gadarene demoniacs (Mt 8:28-9:1), heals a paralytic (Mt 9:2-8), heals a women and restores life to a girl (Mt 9:18-26), heals two blind men (Mt 9:27-31), and heals a mute man (Mt 9:32-34).[12] Culpepper concludes with four implications from these healing stories. First, Jesus' healing was a fulfillment of Scripture. Second, Jesus was moved by compassion and mercy for both Jews and gentiles. Third, there is a link between healing and discipleship. Culpepper suggests Matthew used the healing stories to teach lessons on discipleship. Lastly, the healing stories are ethical models. From the historical and cultural context, these biblical healing narratives point towards a more holistic understanding of healing. The focus then

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[10] Ibid., 7.

[11] Ibid., 1.

[12] Ibid., 2-8.

should be on healing rather than curing, meaning that the goal is to restore the person to a state of well-being and social integration that will require attention to emotional, social, and spiritual well-being along with physical well-being - a model of greater collaboration between healthcare professionals, counselors, and ministers.[13]

In response to Culpepper, Elna Mouton offers three implications. First, Christian healing ministries should be impartial with the unconditional love and compassion of God in Jesus Christ expressed through words and deeds of humble yet powerful service and care. Second, healing ministries need to work towards a vision of an encompassing model where God is relating to humans in the context of human society as well as in the context of the creation. Lastly, healing ministries need to remember that human beings are saved by Jesus Christ and remember the promise of a new heaven on earth. Christian healers should be a "living reminder of Christ's compassion and resurrection."[14]

Donald Capps further supports the notion of Jesus, the healer in his book, *Jesus the Village Psychiatrist*. Capps submits that many of Jesus' teachings are sources of healing as Jesus encourages his listeners not to succumb to anxiety or despair.[15] Based on the stories of Jesus' healing, Capps goes on to state that most of the persons Jesus healed were suffering from a mental or emotional disorder, and the gospel writers believed this as well.[16] Capps continues, stating that Jesus taught his disciples to heal the sick and

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[13] Culpepper, "Jesus as Healer," 8.

[14] E. Mouton, "Jesus as Healer in the Gospel of Matthew: In Conversation with Alan Culpeper," *In die Skriflig/ In Luce Verbi* 50, no. 1, (2016): 6, http://dx.doi.org.fuller.idm.oclc.org/10.4102/ids.v50i1.2143.

[15] D. Capps, *Jesus the Village Psychiatrist,* xi.

[16] Ibid., xii.

disabled. This would mean there are healing methods, and ordinary humans could cure the sick and disabled.[17] For Capps, there is a distinction between curing disease and healing illness. He quotes Leon Eisenberg: "Patients suffer 'illnesses'; physicians diagnose and treat diseases … illnesses are experiences of disvalued changes in the status of being in social function; diseases, in the scientific paradigm of modern medicine, are abnormalities in the structure and function of body organs and systems."[18] Capps then argues that Jesus treated illnesses without curing the disease. In other words, Capps suggests Jesus focused on the way to restore the person in society as opposed to curing the disease. This suggests one of the ways Jesus healed was by removing the social stigma of uncleanness, isolation, and rejection. In essence, Jesus healed by intervening in the social context of the physical world.[19]

To summarize, Culpepper suggests Jesus not only healed physically, but also healed emotionally and mentally. Further, Jesus taught his disciples to heal, which means humans may also be capable of providing healing to other humans as taught by Jesus. Specifically, Jesus focused on treating the illness as opposed to curing the disease. Mouton supports this notion with his commentary to Culpepper. Mouton emphasized the significance of the unconditional love of Christ and how Christians should be living reminders of him. Lastly, Capps reinforced the notion that one of the ways Jesus healed was to restore the person as opposed to curing the disease. Although further research

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[17] Ibid., xiii.

[18] Ibid., xvi.

[19] Ibid.

contributing to this body of knowledge can help to substantiate this model, this is a model

that can be implemented with a relatively low level of effort; however, it needs a

significant paradigm shift from focusing on treating the person to treating the disease.

The SOTH project should contribute to understanding the notion of treating the illness as

opposed to curing the disease. In the final section, I offer a discussion on how individuals

can better prepare for mental illness ministries.

## A Case for Mental Illness Ministries and Their Equipping

"He became the kind of man we do not want to be: an outcast, accused, crucified.

*Ecce homo*!"[20]

In *The Crucified God*, Jürgen Moltmann makes a case for God's humility through

the de-humanized Christ on the cross. In his suffering, Christ is with the de-humanized.

Moltmann reminds us that Jesus Christ is among us in all of the brokenness of humanity.

Pain and suffering are a part of humanity, but Christ is in the mix with humans. For those

with severe mental illnesses, Jesus Christ is the embodiment of the crucified God, and

humans can seek his healing and his liberation. The crucified God is the source for

freeing the mentally ill from their obsessive ideas and actions and providing a path for

love and unconstrainted sympathy with life.[21] Ultimately, they become free from

imprisonment and the vicious circle of death.[22] For Moltmann, it is moving from freedom

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[20] Moltmann, *The Crucified God*, 295.

[21] Ibid., 422.

[22] Ibid., 422-423.

of faith into the freedom of experience and actions.[23] The vicious cycle of death includes

being in poverty, dominated by the power of external forces, weighted down with racial

and cultural alienation, captive to industrial pollution, and senselessness and god

forsakenness.[24]  Moltmann offers ways toward liberation from these five vicious

cycles.[25] Economically, liberation means satisfying materials needs. Politically, it means

being free from oppression. Culturally, it means having an identity and being recognized

by others. Environmentally, it is relative to being in peace with nature. Lastly, in relations

with man and society, it is about having a life filled with a sense of meaning: "Who needs

a doctor: the healthy or the sick? Go figure out what this means: 'I am after mercy, not

religion.' I'm here to invite outsiders, not coddle insiders" (Mt 9:12-13).[26]

In Richard Beck's *Unclean*, Mt 9:13 takes center stage as Beck reflects on why

society systematically keeps marginalized people at a distance.[27] The mentally ill are

amongst the marginalized population. Beck suggests the psychology of disgust is in play

and creates boundaries between those included and those excluded from society. Beck

then suggests that God's mercy crosses barriers and removes boundaries and offers

hospitality to the excluded. For Beck, "Disgust is the primary process erecting boundaries

between the self and the world. Conversely, love is a secondary process that allows others

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[23] Ibid., 424.

[24] Ibid., 480-484.

[25] Ibid., 484-490.

[26] Peterson, *The Message*. Mt 4:23–24, Logos Bible Software 7

[27] Beck, *Unclean*, 2,

access to the "territory of the self."[28] Hospitality is quintessential for Christians.[29] Welcoming strangers and offering hospitality should be extended to the mentally ill. While the dynamics of disgust and dehumanization foster exclusion and expulsion, the practice of hospitality welcomes the outcast and stranger as a full member of the human community.[30] It shows the love of Christ to brothers and sisters. Believers are to "welcome those who are weak in faith, but not for the purpose of quarreling over opinions" (Romans 14:1).[31] How then should hospitality to extended to the mentally ill? I refer to the writings of Henri Nouwen and Jean Vanier to further this discussion.

Henri Nouwen and Jean Vanier provide models for ways to engage the mentally ill. Interestingly, they share similar views and thoughts on sharing God's love with the mentally ill. For Nouwen, community happens when people are with each other:[32] "Community is a fellowship of people who do not hide their joys and sorrows but make them visible to each other in a gesture of hope."[33] In a community, life does not have to be lived alone. Being in community means the members' individual wounds become sources of healing as a part of a fellowship of mutual care. The community is a

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[28] Ibid., 120.

[29] Ibid., 121.

[30] Ibid., 124.

[31] Ibid.

[32] Nouwen, *Can You Drink the Cup?* 63-64.

[33] Ibid., 63.

fellowship of little people who together make God visible in the world.[34] Nouwen claims that the greatest healing comes from being in community.[35]

Vanier also describes the significance of being in community. In *Community and Growth*, being in community creates a sense of acceptance[36] and belonging,[37] fosters forgiveness,[38] and encourages a mission of restoration.[39] Acceptance means "the favorable reception of someone or something. God, in his grace, accepts human beings, their worship and their offerings. People are to accept Jesus Christ and the message of the gospel and to respond to being accepted by accepting one another."[40] This definition seems to suggest that God's acceptance of humans is unconditional. Vanier states that human beings are called and accepted by God just as they are with no preconditions. Furthermore, God will put them in communities of people they may not want to be with. The issue is not about being put into an ideal community. Instead, it is about loving those whom God has set beside one as they are signs of God.[41] "Community is a place of belonging, a place where people are earthed and find their identity."[42] In *Becoming*

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[34] Ibid., 64

[35] Ibid., 65.

[36] Ibid., 44.

[37] Ibid., 13.

[38] Ibid., 35.

[39] Ibid., 84.

[40] Martin H. Manser, *Dictionary of Bible Themes: The Accessible and Comprehensive Tool for Topical Studies* (London: Martin Manser, 2009). 6602.

[41] Ibid., 44-46.

[42] Ibid., 13.

*Human*, Vanier further elaborates on belonging: "Society must, by definition, be inclusive of the needs and gifts of all its members; … those we most often exclude from the normal life of society, people with disabilities, have profound lessons to teach us. When we include them, they add richly to our lives and contribute immensely to our world."[43]

Martin Manser defines forgiveness as "the freeing of a person from guilt and its consequences, including punishment, usually as an act of favor, compassion or love, to restore a broken personal relationship. Forgiveness can involve both the remission of punishment and the cancellation of debts."[44] Forgiveness starts with oneself. For Vanier, "When we accept that we have weaknesses and flaws, that we have sinned against God and against our brothers and sisters, but that we are forgiven and can grow toward inner freedom and truer love, then we can accept the weakness and flaws of others."[45] This is where true forgiveness begins.

Vanier offers three principles of forgiveness.[46] The first principle states there is no forgiveness of people or of others unless they believe that they are all part of a common humanity and they are all equals.[47] The second principle states: "To forgive means to believe that each of us can evolve and change, that human redemption is

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[43] Ibid., 44-45.

[44] Manser, *Dictionary of Bible Themes*, 6652.

[45] Vanier, *Community and Growth*, 35.

[46] Ibid., 153-154.

[47] Vanier, *Becoming Human*, 153.

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possible. We often lock people up in ready-made judgments, 'He is a thief; she is disabled; he is schizophrenic.' … They are people who, if loved, helped, and trusted, can in some small way recognize their faults and their brokenness and can grow in humanity, in inner freedom, to do little acts of love."[48] The third principle is "To forgive means to yearn for unity and peace. Unity is the ultimate treasure. It is the place where, in the garden of humanity, each one of us can grow, bear fruit, and give life."[49]

Vanier also coined the term *accompaniment* as a way of expressing the reality of being alongside people as a companion and friend in order to help them grow in freedom and in the spirit of the community. Vanier distinguishes three forms of accompaniment. Spiritual accompaniment touches the deepest part of one's being, life in the spirit, and one's union with God. Work accompaniment relates to "walking" with a person and establishing accountability for the work assigned to an individual by someone of authority in loving ways. Community accompaniment relates to people outside of the immediate group who develop more personal relationships and provide guidance and advice on the ways and norms of the community.[50] Vanier suggests some people need psychological accompaniment due to emotional and mental issues. Individuals needing psychological accompaniment would require professional, psychological, and specialized spiritual support to drive towards inner healing and wholeness.[51] A community where accompaniments flourish seems to be the ideal scenario for supporting the mentally ill:

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[48] Ibid., 154.

[49] Ibid.

[50] Vanier, *Community and Growth*, 249-251.

[51] Ibid., 250-251.

The Spirit of the Lord is upon me, because he has anointed me to bring good news to the poor. He has sent me to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free, to proclaim the year of the Lord's favor (Lk 4:18-19).

Beck, Nouwen, and Vanier all support the notion of being restored by Moltman's Crucified God. By being in a community where the sharing of the good, bad, and the ugly are the expectation as opposed to the exception, the restorative powers of the Crucified God can begin to work in all humans. For me, the ultimate goal is to recognize the saving grace that can only come from a Crucified God and to be willing to follow God into the community he puts each person into.

## Framework for Mental Illness Ministries

This section is a discussion of the rationale for creating a framework for worship services at mental health facilities. The primary reason is to take up Jesus' mantel and follow him and go to the marginalized. For the SOTH project, the marginalized are those with mental illnesses. Ministry to these marginalized ones means, in particular, creating a community as described by Nouwen and Vanier where the mentally ill can be restored with a sense of acceptance and belonging: a community where forgiveness and healing for all can take place, where accompaniment is promoted, and where opportunities for restoration are present.

There are many layers of marginalization for the mentally ill. Many of the mentally ill are intentionally or unintentionally outcasts of society. In their communities, they have lost the connections and relationships they once enjoyed and relied on. The churches they grew up in may intentionally or unintentionally have kept them at a

distance and shunned them. They may have become socially alienated on many fronts, including the church. Many churches are not prepared, nor do they have the facilities to support a safe environment to start and sustain a mental illness ministry. Conversely, the mentally ill residing in mental health facilities have limited access to transportation, which makes it difficult to get to church. Furthermore, churches typically do not provide off-site services at mental health facilities.

There are many barriers that hamper opportunities for mental health ministries. For example, a family member shared how she and her family had invited their mentally ill brother to a restaurant for a meal. The brother did not know how and what to order as he had not been in a restaurant for over thirty years due to his illness. A mentally ill person coming to a church may experience the same type of challenge as in this restaurant scenario. There are multi-faceted disconnects and misunderstandings on the part of all involved. Sadly, many of the stakeholders are not aware of these disconnects and barriers.

Carlin engaged in ministries for the mentally ill as a part of a Master of Divinity program at Princeton Theological Seminary. As a part of his program, he did a summer internship at a psychiatric hospital in New Jersey and a year-long internship in Scotland. Carlin noticed significant differences between the mental health systems in the United States and in Scotland. He saw a much more humane approach in Scotland than in the United States. In the former, patients had a sense of acceptance, belonging, and dignity. Carlin is also a wounded healer as one of his family members has a mental illness. After Carlin's initial experience with mental illness, he continues to lead worship services at mental health facilities.

Although my journey into ministries to the mentally ill is different from Carlin's journey, there are some similarities. For instance, I am also a wounded healer with a mentally ill family member. I have experienced and witnessed the mental health system in Hong Kong as well as in the United States, and have seen the more humane approaches to treating mental illness outside of the United States. Carlin and I differ in how we entered this type of ministry. For me, it was not to fulfill internship requirements. Instead, I desired to understand how a God who loves humans can allow mental illness to de-humanize people. Furthermore, I wanted to know what churches should do in response to this crisis in the United States.

In part one, I collected information of the current state of mental illness in Orange County, California. The literature review helped me to understand the various mental health ministries that are active at present. These ministries support Nouwen and Vanier's notion of a human need to be in community. Although there are many success stories in many local applications, there seems to be a lack of focus on how to bring the gospel to the mentally ill and expand the experience of community in mental health facility settings in the United States. There is a need to create a multiplier for mental illness ministries. We can achieve this by creating communities where hope and restoration reign.

As a summary, the SOTH project framework can incorporate components of hospitality, community, acceptance, forgiveness, accompaniment, belonging, and restoration into a healing ministry for the mentally ill. The purpose is to empower those whom God has put together in a community as one.

The next chapter is a discussion of the specifics for planning and implementing a mental illness ministry. Using various sources, I have developed an initial model and revised it to be better aligned with the need for being in community.

PART THREE

MINISTRY PRACTICE

CHAPTER FOUR:
PLANNING FOR WORSHIP AT MENTAL HEALTH FACILITIES

To support this SOTH project, I relied on the works of several researchers. Carlin served as the primary reference source.[1] Carlin's reflections from his experiences conducting worship services at a psychiatric hospital played a significant role in the development of this worship service project. The first significant contribution from Carlin was his comments on the significance of music, reflecting on Scripture and the sharing of joys and prayers.[2] I incorporated these three factors into the worship program. The second significant contribution was the sample liturgy of the worship service. This sample was helpful in creating the shortened time frame of the service while focusing on the three vital factors of music, Scripture, and prayer. The final significant point from Carlin was his three lessons learned:[3] showing attendees that they matter by taking worship seriously, showing attendees that the worship leaders care, and tell attendees that God loves them both verbally and nonverbally. A smile and eye contact can go a long way. Armed with Carlin's recommendations, the development of a worship program

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[1] Carlin, "Reflections for Clinical Pastoral Education Students," 523-537.

[2] Ibid., p.532.

[3] Ibid., p.535.

began. The next section is a description of the initial interactions with the mental health facility and the particulars for establishing a worship service.

Initially, my thought was to offer worship service at one mental health facility in Orange County. The first facility I approached respectfully declined the offer with no specific reason for the rejection given. I then approached an alternate facility, the Royale Therapeutic Residential Center located in Santa Ana, Orange County. This facility agreed to support the project with the following stipulations. The facility wanted to call the event a "Praise Group" instead of a worship service and wanted it to be interfaith in nature. Royale wanted to invite speakers from other faiths to lead the praise group periodically to foster a diverse approach. Management also wanted to review and approve the content of the service, so it would be aware of the flow, the music, and the message of the service. Lastly, Royale wanted to limit the sessions to no more than forty-five minutes due to concerns about the attention span of the residents. All the stipulations were agreed to, and planning for the first worship was underway.

To gain further clarification for planning the service, I conducted a physical tour of the facility. At Royale, residents reside in several buildings, depending on their condition and treatment needed. Management wanted to hold the services at two facilities on a rotating basis. The services at both buildings are in the day room. These are large rooms with couches and lounge chairs arranged so the residents can socialize during the day and enjoy watching television, reading, playing games, doing arts and crafts, and engaging in other social activities. Each room can accommodate up to twenty people. After surveying the facility and the rooms, planning for the service within the confines of

the space available began. Additionally, I planned for worship services with small groups of no more than 20 attendees.

As the planning for Royale progressed, I received a request to consider another project site from the Oceanview Adult Psychiatric Hospital, located in Long Beach, Los Angeles County. The management of this facility understood the importance of the spiritual well-being of individuals, recognized the significance of this project, and wanted to participate in this effort. Oceanview also gave a few stipulations such as limiting the time to forty-five minutes but did not have any concerns about calling the event a worship service. I conducted a site survey at Oceanview. Similar to Royale, Oceanview had one "Day Room." There were couches, lounge chairs, and tables with chairs for residents to use for activities such as arts and crafts, jigsaw puzzles, and word games. The day room at Oceanview could accommodate up to twenty-five people. Management also asked for a diverse worship program and wanted to invite worship leaders from various faiths to speak at services. Constraints, such as space and time for music ministry, were also applicable at Oceanview.

The initial project plans incorporated the terms and stipulations of both the Royale and Oceanview facilities. As planning continued, several challenges surfaced, and Revision One was put in place. I conducted morning services at Royale and evening services at Oceanview. A discussion of the details of the initial plans and revisions based on feedback and observations is in the next sessions.

**Initial Plans**

The initial plans were to incorporate some components of mental illness and the healing of Jesus Christ in an abbreviated worship service. With consideration for time limits, I developed a shortened liturgy consisted of the following components that was approved by the two facilities:

1. Call to Worship

2. Praise Music (two songs)

3. Scripture Reading with mental illness topics

4. Reflection led by worship leader

5. The Lord's Prayer

6.  Closing Music

7. Benediction and Closing

 The worship team would consist of a worship leader, an assistant, and musicians. During the planning phase of the worship service, I encountered logistical and resource challenges. As the idea was to offer this service on Sunday mornings at Royale, sourcing volunteers and musicians was a challenge as many of the would-be volunteers were engaged in other worship activities. Similar challenges also arose for the evening services at Oceanview. Additionally, setting up and taking down the necessary equipment for music ministry would be a constraint. In light of these challenges and limitations, I decided to launch a modified pilot program with only the worship leader at both facilities. Instead of an assistant to meet and greet attendees, the worship leader would assume this role. Instead of musicians, the service would rely on portable music via a smartphone and

a portable speaker. These initiatives enabled flexibility and removed the constraints of finding volunteers and scheduling and their associated logistics.

At the end of each worship service, the worship leader would complete an observation form with comments relative to the interactions, the content, and the quality of the service. Comments and suggestions from the attendees, as well as from the staff and notes from observations, would also be documented. I would review the recommendations to determine potential modifications. From these initial assessments, I would consider revisions incorporating improvement initiatives.

Although we did not launch the first iteration of worship service plans, it provided a wealth of information for future plans. In the next section, I will discuss the revised version used to start this project.

**Revision One**

With lessons learned from the planning of the initial launch, downsizing and right-sizing seemed to be the appropriate approach going forward. To this end, the program no longer needed musicians and assistants. Instead, the revised plan would consist of only the worship leader providing worship service in a low-profile fashion. Music would be played via a smartphone and a portable speaker. One of the spin-off benefits of utilizing mobile music is the ability to incorporate a much broader array of praise and worship music from a variety of genres and traditions that would be challenging for live musicians to replicate. As a result, a wider range of diversity in audience-appropriate music selection could be offered, and new opportunities for music

ministries in such settings opened up. I will reflect on the significance of the music

ministry in the next chapter. This revised plan also eliminated the need to coordinate

teams of people, and scheduling became a much easier task. In essence, downsizing and

right sizing offered flexibility, less planning, and reduced complexity, and widened the

window of ministry opportunities to serve the varied demographics of the attendees

better. In essence, this approach incorporates a more extensive range of praise music

genres into a worship service. A service can start with traditional praise hymns, switch to

gospel songs, and end with contemporary praise music, offering the attendees a variety

and diversity of music.

Although the revised plan had significant benefits, it also had some potential

negative effects. For example, inputs and observations would be fewer as only one

observer would be present, as opposed to many observers. In addition, the quality of the

service would be diminished by the lack of variety and activities from other members of

the worship team. However, I accepted these concerns as the number of the attendees

would be relatively small and would have minimal impact. Average attendance was

estimated to be ten to fifteen, which would be manageable with one worship leader and

one attending staff from the facilities. With this low number of attendees, the worship

leader could provide the needed attention to the worship service and still have the

capacity to observe the proceedings. Another spin-off outcome would be the willingness

of the on-site staff to assist with the worship service by providing comments from their

interactions with the residents and observations, which would then be documented on the

observers' form.

This version of worship service was launched on July 7, 2019 with an acknowledgment that further refinements may be warranted. No significant issues or challenges were observed. Portable music in a small setting seemed an appropriate approach for this population. In this situation, the low-key format and flow of the service seemed to be a benefit as opposed to a deficit.

As the initial feedback and assessment from both facilities were positive, and the Revision One launch seemed to be well received, management from both facilities was supportive of this ministry and encouraged the worship services to continue as this activity filled voids in spiritual formation in their respective programs. Both facilities fully understood and appreciated the need for this and similar programs for their residents. The attending staff at Royale commented on the value of the Scripture reading as it provided the attendees an opportunity to reflect on the meaning of the message from their perspective. Another comment was that the timing of thirty to forty-five minutes was "just right." Similar comments also came from the Oceanview staff.

I then wondered whether it would be possible to introduce some of the worship service components that had not been included due to time constraints and concerns for the attention spans of the attendees. Revision Two included these additional items and is discussed in the next section.

**Revision Two**

Revision Two incorporated changes based on observations, comments, and recommendations collected from the weekly services.  According to E. Mouton, a

ministry of healing must be characterized by the impartial, unconditional love and compassion of God in Jesus Christ. This type of ministry should incorporate components for building relationships with God, society, and creation. It should be a living reminder of Christ's compassion and resurrection power.[4] The following describes the changes of Revision Two in the interest of creating a more relational worship environment.

During the initial planning stages, I wanted to include the Eucharist, using bread and a cup for intinction. The management at both facilities rejected this proposal. The reason was hygiene concerns and the fear of health-related issues for the residents, staff, and the worship leader from passing solids and liquids between participants. The management of both Royale and Oceanview requested to review the physical materials (the bread and the wine) and the instruments to be used as the facilities had to ensure unauthorized materials and items were not introduced. I suggested using a portable communion kit with wafers and individual cups. The management also rejected this option as it still raised contamination concerns. I then introduced the option of using fellowship cups as an alternative to reduce the probability of contamination. These self-contained communion kits would reduce the likelihood of exposure. Each participant can open their kit and not have to share it with others. The management of both facilities approved this approach, and communion became a part of this revision. Chapter five includes a review of the observations and challenges from serving the Eucharist.

One of the comments from the worshipers was a desire to pray more during the service. Many of the attendees recognized the importance of prayer and wanted

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[4] E. Mouton, "Jesus as Healer," 5.

opportunities to pray together in a community. They wished to pray not only for those in attendant, but to also pray for their fellow residents, for family members, and for communities, among other requests. To satisfy this need, in this revision, prayer requests were incorporated into the service. Chapter five also contains further comments and reflections on the significance of prayer requests for mental illness ministries.

The attendees were also eager to engage and participate in the worship service. The residents wanted to be involved and be active participants during worship. We started volunteer-led Scripture readings to facilitate attendee participation. Volunteers would take turns reading the Scripture passages and would then engage in a group discussion about the texts.

Another question was whether each of the services needed to have a mental illness specific topic. Coming up with mental illness-related issues every week can be a challenge. In Revision Two, I started to use a standard lectionary, which was significant as it reduced the time needed to prepare for the weekly worship service. Chapter five also contains a reflection on ways to prepare for weekly mental illness worship.

This second revision launched on August 4, 2019 with several new initiatives incorporated: volunteer-led Scripture reading following the standard lectionary, prayer requests, and the Lord's Supper in the following order:

1. Introductory Praise Song

2. Call to Worship

3. Praise Song (one song)

4. Volunteer-led Scripture Reading

5. Worship Leader-led Reflection

6. Prayer Requests

7. The Lord's Prayer

8. The Lord's Supper

9. Closing Praise Song

10. Benediction and Closing

The launch of Revision Two with these additional activities seemed well received. With

the inclusion of the prayer requests and the Lord's Supper, the interactions between the

worship leader and the attendees increased significantly. Services utilizing the flow of

Revision Two continued, and further comments and observations were collected. The

next section is a discussion of the third revision incorporating the recommendations and

observations from Revision Two.

### Revision Three

> It is not the task of the Christian leader to go around nervously trying to redeem people to save them at the last minute, to put them back on track. For we are redeemed once and for all. The Christian leader is called to help others affirm this great news, and make visible in daily events and facts that behind the dirty curtain of our painful symptoms there is something great to be seen: the face of Him in whose image we are shaped.[5]

Following the words of Henri Nouwen, in this version, the theme was to make

Christ more visible and approachable amid people's pain and suffering. In consideration

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[5] Nouwen, *The Wounded Healer*, 43.

was the incorporation of items that could let people know that God is in the present, and his love and compassion are always available for all.

After the implementation of the second revision, the average time of this abbreviated service was thirty-five minutes, which offered an opportunity to add in a few other activities and still stay within the forty-five-minute window. My first thought was to incorporate Confession and Forgiveness right after the Call to Worship. Although this addition was very simple and relatively quick, the attendees looked forward to and eagerly participated in reciting the pardon of forgiveness. Perhaps their desire showed a recognition of the need to be forgiven. Because of the additional time, I added a praise song before the start of worship. This praise song would play while attendees were coming into the service. The engagement of volunteers in the Scripture reading was expanded to enable volunteers to lead the reflection as well.  Finally, the group started sharing God's love in the prayer request time. The following is the flow of worship for Revision Three:

1.  Introductory Praise Song (listen as attendees entered)

2.  Call to Worship

3.  Confession and Forgiveness

4.  Praise Song (two)

5.  Volunteer-led Scripture Reading and Reflection

6.  Prayer Request and Sharing of God's Love

7.  The Lord's Prayer

8.  The Lord's Supper

9. Closing Praise Song

10. Benediction and Closing

One interesting observation was the attendees' desire to request praise songs. It seemed that many of the attendees were well acquainted with worship services and wanted to be active participants in the planning of worship. A request for praise songs was incorporated at the end of the service to support the attendees' wishes.

**Summation and Evolution of the Worship Service Program**

From the launch of the first worship service, I incorporated several significant and fast-paced changes to serve the attendees better. The goal was to continue to build upon Carlin's lessons of taking worship seriously, developing trust, and showing God's love. I monitored and observed the impacts of these changes and documented and analyzed them weekly. Table 4.1 shows a summation and evolution of the changes going from Carlin's recommended list to Revision Three.

Table 4:1. Evolution of Liturgy from Carlin's Recommendation to Revision Three

| Carlin's List | Initial Plan and Revision One | Revision Two | Revision Three |
|---|---|---|---|
| | Launched: July 7 | Launched: August 4 | Launched: October 13 |
| • Moment of Silence<br>• Opening Sentences<br>• Call to Worship<br>• Hymn<br>• Call to Confession<br>• Prayer of Confession | • Call to Worship<br>• Praise Music (2 songs)<br>• Scripture Reading with mental illness topics<br>• Reflection led by worship leader | Items Added:<br>• Introductory Praise Song<br>• Prayer Request<br>• The Lord's Supper<br><br>Items Revised:<br>• Praise Song (I song) | Items Added:<br>• Confessions and Forgiveness<br>• Sharing of God's Love<br>• Praise Music request for next service |

| | | | |
|---|---|---|---|
| • Declaration of Pardon<br>• Joys and Concerns<br>• Hymn<br>• Pastoral Prayer and the Lord's Prayer<br>• Scripture Reading and Group Reflections<br>• Hymn<br>• Benediction | • The Lord's Prayer<br>• Closing Praise Song<br>• Benediction and Closing | • Volunteer-led Scripture Reading: no need to be mental illness focused<br>• Closing Praise song<br>• Benediction and Closing. | • Items Revised: Introductory Praise Song (no singing)<br>• Praise Songs (two)<br>• Volunteer-led Scripture Reading and Reflection |

The first column is the outline from Carlin's liturgy. The second column is the outline of the initial plan and Revision One. The liturgies of these two versions are identical. In the initial release, musicians and other volunteers played a part. However, because of logistics, resources, and space constraints, I downsized the team to include only the worship leader. These initiatives changed the focus to portability, for example, music from a smartphone and a Bluetooth speaker, while a meaningful service was still provided.

Revision Two had several changes. One of the two praise songs was moved to the beginning of the service and functioned as an introductory praise song. Volunteers read the Scripture and the worship leader led the group Scripture reflection. This version also incorporated prayer requests similar to a small group setting. The Lord's Supper was also incorporated.

A third revision was launched on October 13, 2019.  In this version, the introductory praise song was changed to listening only, and it served as introductory music while people were coming to the service. The confession of sin and forgiveness of sin were incorporated. The service also reverted to two praise songs right after the confessions of sin and forgiveness of sin. Scripture reading and reflections became completely volunteer led. This version also included a time to share God's love in the prayer request time. The final update of this revision was to add an opportunity for attendees to offer praise music requests for the next service.

**Assessment and Data Collection**

For assessment purposes, I collected and analyzed data at various points throughout this project. I was interested in observations, reflections, and comments from myself as the facilitator, the staff at the residents who facilitated the worship services, and the resident worshipers. From my own observations, I collected my self-reflections, and my notes on opportunities for improvements and results from the various changes. Appendix A is a summary of my notes, comments, and observations. Inputs and comments from participating staff are summarized in Appendix B. I collected comments relative to the real or perceived benefits for the residents as well as for the facility from the staff. Additionally, participating staff provided comments on improvement opportunities. The residents also had opportunities to share their experiences. They were asked to provide feedback and share whether they felt a sense of being in a community in Christ and the opportunities they saw for spiritual formation and growth. Their feedback

is listed in Appendix C.  Appendix D is a list of the residents' prayer requests. This is a

significant portion of the assessment as this set of information provides insights into the

feelings, relationships, and emotions important to the residents. Finally, Appendix E is a

list of the worship services including the location, date, time, number of attendees, and

the theme of the message.

CHAPTER FIVE:
SUMMARY OF FINDINGS, ASSESSMENT, AND EVALUATIONS
FROM WORSHIP EXPERIENCES AND OBSERVATIONS

The findings from this project contribute to a better understanding of how churches can develop more meaningful avenues for engaging those who are mentally ill and desire to have relationships with a church. There are several sections in this chapter. The first part is an overview of the findings from the services at both Royale and Oceanview. The second is commentaries on the significance of worship services for the residents and the staff at both facilities. The third is an assessment of the significance of the various components of the worship service from observations, interactions, and input from the residents and the attending staff. Part four is an assessment of common themes in these two facilities from myself, the residents, and the participating staff. Part five is a discussion on the implications for churches interested in venturing into mental health or other similar ministries. Part six identifies the limitations of this project and suggests activities for future consideration that can further expand the field of study in this area. Lastly, in the conclusion, I offer my thoughts and reflections from this project. Specifically, I contemplate what I learned about being in community with the mentally ill.

Although I completed the data collection portion of this project by the end of December 2020, services will continue at both facilities as requested by the management of both sites. I will continue to make observations and collect data during services for future consideration.

**Overview of Findings at Royale and Oceanview**

The following is a brief summary of the general findings at Royale and Oceanview which includes general information about these two facilities, the demographics of the residents, the culture of the facility, the management approach to worship services at each facility, and observations of the residents.

The Royale Therapeutic Residential Center can accommodate 124 residents in three units. Unit One houses forty residents, Unit Two houses forty-eight residents, and Unit Three accommodates thirty-six residents. Worship services have taken place in Units Two and Three. The average length of stay at these two units is from three to six months. The most common diagnoses Royale treats are schizophrenia, schizoaffective disorder, and bipolar disorder. In Units Two and Three, the population is a mix of men and women of diverse ethnicities, ages, backgrounds, and mental conditions. The culture in these units is a collaborative open approach between the residents and the staff. Residents are encouraged to become active participants and make recommendations to the staff for improvements. In turn, the staff is receptive to the residents' suggestions. One staff member oversees the worship services at both units and is an active participant during the service.

Oceanview has only one unit. Logistically, the facility is much easier to manage than Royale. Oceanview is also a smaller facility and houses an average of twenty-six residents. The average length of stay is seven to ten days. The common diagnoses are major depressive disorder, bipolar disorder, schizophrenia, and schizoaffective disorder.

Oceanview is a smaller facility, fewer people came to the worship services but the number is proportionate to the total number of residents. The population at Oceanview is also a mixture of men and women from diverse ethnicities, ages, backgrounds, and mental conditions. At Oceanview, there is also a collaborative atmosphere, in which the residents and staff engage and interact constantly. Although one of the staff is assigned to oversee the service, this individual departs during the service as it is the end of the shift. As such, interaction and participation of the supporting staff at Oceanview is less than at Royale.

Although the initial thought was that the attending staff would have minimal impact on the spiritual formation of the residents coming to the service, staff involvement has turned out to be a crucial factor. This is evident by the number of attendees and the level of resident participation at Royale. The attending staff interacts with the residents during the service as well as participate in the service. For instance, the staff at Royale participates during communion while the supporting staff at Oceanview does not participate. The staff at Royale also participates during the Sharing of Joy and Prayer Requests. As a participant, the supporting staff person becomes a part of the Christ-centered community and encourages resident engagement. If this staff member is willing to become an active participant, the value of the worship service for the residents is

enhanced. Appendix A, Table 5.2 provides a summary of the observations, comments, and recommendations from the worship leader and the supporting staff. The main conclusion is the recognition of the importance of engaging the worshipers and the willingness to make changes to create a meaningful worship service for the residents. At the start of this project, I made assumptions about the limitations and constraints relative to worship for the mentally ill. From the inputs from the residents, I soon discovered that many of my initial thoughts and assumptions could be improved upon. Many of the comments and recommendations were incorporated to enhance the worship service for the residents. This collaborative approach created the path for enabling meaningful relationship building, worship, and spiritual growth. In addition to the residents growing spiritually, I was also given an opportunity to grow spiritually.

The average number of attendees at Royale was eleven and the average at Oceanview was six. At Royale, the maximum attendance was fourteen and the minimum was six. At Oceanview, the maximum attendance was eight and the minimum was three. The total number attendees at Royale was 251 and at Oceanview was 114. Relative to the total population of these two facilities, the attendees represented approximately 10 percent of the population at each facility.

**Benefits of Worship at Mental Health Facilities for the Mentally Ill**

Mental health ministry can offer many benefits to the residents. Additionally, family members and caretakers can also benefit. The findings from this project suggest there are direct and indirect benefits. For example, the support and interactions of the

attending staff have a direct benefit to the residents. There were also indirect benefits for the staff and family members. I will describe some of these benefits in the passages below.

I witnessed empowerment, accompaniment, and belonging in a community made up of residents, staff, and the worship leader. The residents were in a safe space where their differences were appreciated and accepted rather than being singled out, frowned upon, and rejected. There was a non-judgmental atmosphere where the residents were free to openly express their thoughts and feelings about God, Jesus, the Holy Spirit, family members, friends, staff, and others. In essence, the focus of the worship was on God and being in relationship with God. Staff engagement and participation also reinforce accompaniment and community for the mentally ill. The idea of just being there and be willing to listen without prejudice is a significant factor in recognizing those who are in attendance.

Being in community is very likely the most significant contribution of the worship services. The community creates and encourages paths for genuine worship unconditionally with no pre-conditions and expectations. Residents are free to engage in dialogue with me as the worship leader, the staff, and their fellow residents. There is a sense of accompaniment as the worship leader, staff, and management encourage and create an environment to enable relationship-building. Being in this community also creates a sense of belonging. The residents are constantly getting reinforcements of God's love, and they belong in this community. There is also safety where residents can come as they are as opposed to being singled out or even asked to leave at a church. With a

non-judgmental approach, residents are learning how not to judge others and focus on loving their neighbors. They are told that just a smile can go a long way in many instances and can be a way to defuse as oppose to escalating a situation.

Appendix B, Table 5.3 shows input and comments from the supporting staff and management. I focused on three specific areas. The first was the contributions of this project towards the goals and objectives of the facility. The responses indicated that the efforts filled gaps identified by the facility as well as requests from residents. The second area was observable changes at the facility. The responses indicated this effort contributed to a decrease of overall tension and anxiety. The third area was whether this project is contributing to the spiritual well-being of the residents. The response indicated the feedback received from the residents was positive. These responses support the contributions from conducting on-site worship services. Comments on supporting the goals and objectives of the facility, supporting the residents, and contributing to the spiritual wellbeing of the residents were all positive, indicating the worship services are enabling a Christ-centered community.

Appendix C, Table 5.4 contains comments and feedback from residents. The staff at Royale suggested conducting a simple survey with the residents to solicit their thoughts and opinions. The results suggest residents have created a Christ-centered community and are spiritually connected with God. Residents provided feedback via a survey containing questions relating to whether the worship service supported their spiritual needs, overall well-being, and a sense of belonging to a community. On a scale of 1 to 5, the average score was 4.5. Overall well-being scored the highest at 4.7 and

supporting spiritual needs scored the lowest at 4.3. Of all the worship activities, music scored the highest at 4.9 and sharing of joys and prayer requests scored the lowest at 4.4.

## Significance of Worship Components

One of the major discoveries was the significance of the various aspects of the worship service. Attributes such as music, participation, prayers, sharing of joy, and the Lord's Supper are of particular importance to the residents. The following is a summation of the observations, notes, and comments from myself, the attending staff, and management of both Royale and Oceanview.

Music is likely one of the most significant aspect of the service. By converting to portable praise music, a wider variety and range of music has been made possible. The residents have gravitated towards the music. Music is a way for many of the residents to connect with God. Many residents sing along with songs they know. Some of the residents sit quietly and follow along reading the words of the praise songs from the program. When a popular, uplifting song is played, some of the residents will get up and dance to the music. More interesting is how many of the residents know, appreciate, and enjoy listening and singing to praise songs. Some of the residents would comment on how long it had been since they heard a particular praise song. After two months of worship services, praise song requests became a popular theme. Residents would request praise songs they knew. In many ways, God has been using music to connect with the mentally ill. It seems that many of the worshipers have had a relationship with God at

some point, but their illnesses have set them apart from God. Through music, the residents are able to get reacquainted with God and re-establish relationships with God.

The worshipers also enjoy participation and being a part of the worship service. When the worship service began using volunteers reading Scripture and leading discussions, there were more volunteers than needed. To accommodate all the volunteers, the Scripture readings were parsed into smaller parts so the volunteers could take turns reading and leading discussions. This is indicative of the residents' desire to belong and be in community.

Sharing of Joy and Prayer Requests have become a very special time during worship. One of the common prayer requests is to be discharged from the facility and go home. Other common prayers are for the safety, health, and welfare of family members. The residents also pray for their fellow residents, staff members, and for their communities. The more touching prayers relate to their mental illnesses. Some request that the voices go away, that they might have the ability to control their depression and anxiety, and that God would assist them to keep from doing bad things. A collection of the various prayer requests is illustrated in Appendix D Table 5.5. The locations and the dates of the worship services are listed on this table along with the collection of prayer requests. Specific information such as names and other information is omitted to maintain confidentiality. Table 5.1 is a summary of the prayer requests broken down into six categories. Of these six categories, 48 percent of the prayers were for family and friends. Being discharged and be able to go home comprised 14 percent. Personal well-being accounted for 13 percent and spiritual well-being for 12 percent. It appears the desire for

family relationships was a significant factor for the majority of the residents attending services. Further, they were asking for God's guidance in their relationships with their family members.

Table 5.1 Prayer Request by Categories and by Percentages

| Categories | Discharge/Go Home | Family and Friends | Mental Health | Physical Health | Spiritual Well-being | Personal Well-being |
|---|---|---|---|---|---|---|
| Number of Prayer Requests | 29 | 99 | 19 | 10 | 25 | 26 |
| Percentage Relative to all Prayer Requests | 14% | 48% | 9% | 5% | 12% | 13% |

The last significant component of the worship service is the Lord's Supper. When the Eucharist was finally approved by management, the residents responded positively and looked forward to receiving communion. As a group, we had to overcome the learning curve of using self-contained communion kits. These kits are in two parts. The first part is the wafer which is underneath a clear plastic seal and a tab needs to be pulled to get to the wafer. The second part is the juice which is underneath a metal seal and a tab also need to be pulled to open it. Many of the residents had difficulties opening the clear plastic tab. This may be indicative of their decreased manual dexterity due to their illness. Interestingly, during the communion, those who could open the communion kits would help those who needed assistance. Again, I see this as being in a community.

Although some of the residents experienced difficulties with the kits, many of them recognize the importance of communion. There were times when latecomers would ask if they had missed the communion. Some latecomers ask for communion after the service. Sadly, some do not think they are worthy to receive communion due to pass

transgressions. Interestingly, many staff members also participate in communion. It appears the communion is a bridge builder and is one of the ways to create meaningful community. Communion also has brought up questions. For example, some or the residents did not know what communion was. They had difficulties understanding the "Body of Christ" and the "Blood of Christ." Some were confused and were not sure if they should partake. Other questions came up, for example, does a person need to be baptized before they can receive communion? In retrospect, it may be a good idea to consider offering courses such as Introduction to God and the Church at these facilities as another opportunity to be in community.

## Common Themes

From the observations and the interactions, a few common and interesting themes surfaced. The first was the behavior of the residents during the worship service. The second was the desire to be in relationship with God. The third common theme was the significance of music, prayer requests, and communion. The last common theme was the importance of accompaniment and being in a Christ-centered community. The following details these common themes.

At both Royale and Oceanview, there are several common behaviors from the residents. On average, approximately 10 percent of the residents regularly attends services. Of this population, some attendees participate fully. Some sit on the sidelines and just observe. Some of this population later engage while others d not. There are also residents who come at various times of the service and depart indiscriminately. They

come and go randomly. There are also others who walk by the room to observe the service but do not come in. Lastly, there are some who do not think they are worthy to be in worship as they have sinned. Some have actually shared their sins with me privately and walked out. Appendix 5.5 shows the number of attendees at Royale and Oceanview. The average number of attendees from Unit Two at Royale is eleven, from Unit Three is ten, and at Oceanview is six.

Regardless of the level of engagement, the desire to be in relationship with God is apparent. Based on the behavior patterns observed, some of the residents wants to engage and are comfortable in the worship setting while others are not ready to engage. Further investigation is needed to better understand this phenomenon. The need to be in relation with people is also apparent. During the worship service, attendees interact with each other, especially during Scripture discussions and the Sharing of Joy and Prayer Requests time. Having a safe space for worship where all are invited with no pre-conditions and no judgment creates a welcome theme for all. Having on-site worship provides opportunities for the residents to responded in their own ways.

Several of the worship activities such as music, Scripture reading, Sharing of Joy and Prayer Requests, and Communion are very popular with the residents. At just about every service, someone comments on the praise music and says how the music is influencing them spiritually. Participation during Scripture reading is also a popular and common theme. At both facilities, attendees eagerly volunteer to read and discuss the passages. Many of them would weave in their own stories and talk about God in their lives. Interestingly, some of the residents are well-versed in Scripture and are capable of

carrying intelligent theological discussions. Having worship on-site provides the opportunity for meaningful interactions about God.

The Sharing of Joy and Prayer Requests is also very popular. Residents at both facilities share their desires and pray to God for intervention. Some of the common prayers are about being discharged soon, going home, help with their mental illness, and prayer for the health and welfare of family and friends and also for the staff at the facility. Occasionally, a resident will share that their prayer request has been answered. Some will express their disappointment as their prayers have not been answered. These moments create opportunities for further discussions on prayers and how God answers prayers.

The last common theme is the importance of accompaniment and being in community. In many ways, the desire to just be together in fellowship and be alongside each other is likely one of the most significant themes. Just being there and being receptive to open dialogue on just about anything is appreciated by all. Residents who attend the worship feel a sense of community and are willing to be in accompaniment with their fellow worshipers, the attending staff, and the worship leader. These attitudes suggest that the residents desire to be in a Christ-centered community. However, being in community does not mean all is well. There are times when residents are at odds with each other, resulting in arguments, outbursts, and disruptive behaviors. During these times, the group is reminded of the need to show mercy, forgive one another, and pray for each other.

**Implications**

On the basis of these findings, mental health ministries should focus on being in community as described by Vanier and Nouwen. To achieve this, churches should rethink how they serve the mentally ill and consider ways to become part of a Christ-centered healing community for the mentally ill. This rethinking will mean a paradigm shift in the way churches engage and support the mentally ill. Instead of looking for ways to invite the mentally ill to the church, churches should consider going to the mentally ill in their communities. Instead of focusing on offering hospitality to the mentally ill at church, churches may want to be visible to the mentally ill communities and let them invite the church into their communities. This means to allow the community of the mentally ill an opportunity to extend their hospitality to the church by allowing the church to be a part of their community. These and other similar gestures would empower these and similar marginalized communities and create genuine and meaningful ministries in the churches that seek to interact with them.

The community should include the residents, staff, church members, and management. The focus should be on being in community and seeing the gifts God has given to each individual in the community. Given the right environment and setting, the mentally ill can receive benefits from being in community. Conversely, others in the community can learn to see and appreciate the gifts God has given to the mentally ill and how the church can be enriched by them.

For community to be meaningful, each of its members need to take their role and responsibility seriously. Showing one really cares is an important factor in being accepted

in this community. In instance, the worship leader needs to take this role seriously and take the time and effort to develop meaningful worship appropriate to the community. The attending staff should also take their role seriously. As they are the representatives of the facility, their input or lack of input is clearly visible to all who are present. For instance, the level of staff support is typically higher at Royale than at Oceanview. The staff at this facility engages with the worship service by participating during praise songs, prayer requests, and communion. This participatory approach positively influences the behavior of the residents. This approach also enables the staff member to gain trust and acceptance.

**Limitations**

Although this project provided an opportunity to learn first-hand from the mentally ill, it is just the starting point for understanding how Jesus healed mental illness and how churches can provide healing to the mentally ill. The interactions and observations at Royale and Oceanview are vital in developing mental illness ministries. However, only two facilities were involved in the present study. Other studies at additional facilities can further substantiate the findings from this project. For future consideration, this project had three limitations. First, this effort was a stand-alone project. The data collected, lessons learned, and findings have yielded valuable insights that can contribute to understanding how churches can minister to the mentally ill. Going forward, integrated studies in which faith and therapy are combined may be of interest to further understand the significance of the relationships among faith, medicine, and mental

illness. There seem to be significant gaps in cooperation between the faith community and the medical community. Instead of studying the benefits of faith and medical treatments as independent efforts, there may be value in studying the effects of providing integrated services where faith and medicine are equal parts of the overall treatment.

Second, this project's scope offers only a narrow slice of the overall mental health crisis in the United States. Further studies can expand into other aspects of mental illness including the homeless population, caregivers, family members, and others who are impacted by mental illness can contribute to a broader understanding of this national crisis.

Final, when residents leave the facility, there are limited opportunities for them to find a suitable church for worship and to further their spiritual formation. There is a need to consider developing worship for the mentally ill when they depart these types of facilities. Challenges such a transportation, safe space, time, and other logistic considerations are difficult constraints that need to be considered.

## Conclusions

To facilitate this project, several foundational frameworks were developed. Capps and Culpepper suggest that Jesus often healed illnesses as opposed to curing the disease. For Nouwen and Vanier, restoring people back into community are forms of healing. One of the findings from this project is that there are those within the mentally ill population who desire a relationship with God and want to be restored into a Christ-centered community. Although many churches are aware of a need to serve the mentally ill, they

are not necessarily equipped nor are they prepared to minster to the mentally ill. This is

especially true for serving those with severe mental illness. In essence, many churches

are not ready to become a part of mental health communities. For them, supporting the

severely mentally ill is not feasible with their current infrastructure and mode of

operation.

There is a need for churches to recognize that the severely mentally ill cannot be served

the traditional church model. Churches should rethink ministries for the mentally ill and

consider how churches can become an integral part of the mentally ill communities.

Instead of inviting the mentally ill to come to worship at church, churches may need to go

to them. In my opinion, this is the start of the rethinking process. The findings from this

project support bringing church to the mentally ill by illustrating and highlighting the

benefits of worship services at mental health facilities. In a community, worship services

can be the bridge to enable spiritual formation for residents who would not be able to or

feel comfortable attending worship services at a physical church building.

The findings from this project support several significant attributes for creating a

ministry to the mentally ill. The significance of music is understood in conventional

modern-day worship services. Music is even more significant for mental health

ministries. It can be a major conduit for establishing and sustaining a mental health

ministry. Participation is also an essential component for mental health ministries. Being

involved and given opportunities to be active participants provide a path for the mentally

ill to gain empowerment and belonging. Praying and be able to share prayers in a group

encourages acceptance and shows mutual support. The importance of the Eucharist

cannot be understated. Those who participated in worship at Royale and Oceanview understood the meaning of communion and saw this as a way to receive the grace of God and forgiveness of sins. Staff involvement is also a significant factor. When staff members are involved, they reinforce their acknowledgement of the importance of spiritual wellbeing. All of these initiatives culminate into being in a Christ-centered relational community where all participants share in the unconditional love of Christ.

Reaching out to the mentally ill and removing the stigma of mental illness should be a part of church missions and not be overlooked. Beyond reaching out to the mentally ill, churches should also be in community with the mentally ill person's loved ones, for they too are suffering. In fact, the loved ones are more likely to come to church than their mentally ill family members. Given a safe space, the loved ones may become the catalyst to start mental health ministries.

The last topic to consider is hospitality. My initial thought was to bring the hospitality of the church to the mental health facilities. The idea was that there is a need to bring church to those who are not able to come to church. What I discovered shifted this paradigm and compelled me to rethink hospitality. Instead of the church offering hospitality to the mentally ill, the mentally ill in a community are those that are extending hospitality to the church. In other words, it is the Christ-centered community that offers hospitality to the stranger coming from a church to their community. This is likely one of the most profound findings from this project. Churches should humble themselves to become a part of these and similar communities as a part of their mission.

Going forward, I will be looking to create a model that will enable this type of ministry to multiply. The hope is to create a self-directed mental illness ministry kit so that others who are interested can easily enter into these types of ministries in other communities, for there is a need for the church to become an active participant in the mental illness crisis. Once this model matures, one opportunity is to approach and engage the Orange County Behavioral Health Department and offer this model as a means of offering spiritual formation opportunities to other mental health facilities in the county.

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Table 5.2. Observation Notes and Comments

| Date | Location | Observations and Comments |
|------|----------|---------------------------|
| 7/7 | Royale | • 30 to 35 minutes about right<br>• Residents liked the music<br>• People wanted to interact and introduce themselves<br>• Need to fine-tune prayers and message |
| 7/14 | Royale | • Group was engaging—some more than others<br>• One person commented "I have not prayed in seven years."<br>• Residents made recommendations on music<br>• Looking to start communion next week |
| 7/21 | Royale | • One person came in and immediately left<br>• Music was engaging |
| 7/28 | Royale | • Participants engaged.<br>• Lots of tears and sharing<br>• Desire to be more involved |
| 8/4 | Royale | • Music had a better flow<br>• Participants engaged<br>• Communion was good. |
| 8/4 | Oceanview | • Small group but engaging<br>• Enjoyed music<br>• Started communion<br>• Consider changing the sequence of communion<br>• Need to check lyrics |
| 8/11 | Royale | • Enjoyed the music<br>• People engaging<br>• Liked "God in the City"<br>• Prayer request for traction<br>• Scripture reading needs some work—will ask volunteers to read next week<br>• Wait to pass out communion kits |
| 8/11 | Oceanview | • People engaged with Kurt Franklin music<br>• Volunteer read Scripture and had good discussions<br>• One person spoke incoherently<br>• Communion flow better but need more work |

| 8/25 | Royale | • Music very important<br>• Volunteer readers<br>• Staff participated<br>• Request for Bible<br>• Discussed possibility of adding second service<br>• Prayer request increasing<br>• Communion kits still a problem |
|---|---|---|
| 8/25 | Oceanview | • Music was appreciated<br>• One person disruptive—people tried to stop this person<br>• Made adjustment for communion kits - better |
| 9/1 | Royale | • Music moving people. Some stood up and danced<br>• Communion still needs work<br>• One person disruptive |
| 9/1 | Oceanview | • Mixed music well received<br>• Communion kits were problematic—people not able to open the wafer tab.<br>• Residents asking difficult questions<br>• A few residents studying Scripture |
| 9/15 | Royale | • Music continues to be high point<br>• Prayer requests becoming common<br>• Many prayers for family, mental illness, and peace |
| 9/15 | Oceanview | • Attendees enjoyed the music<br>• Residents continue asking difficult questions—i.e. why is there mental illness?<br>• Mental illness-related prayers |
| 9/22 | Royale | • Call to worship was good<br>• People wanted involvement<br>• Asking questions<br>• One person was walking outside of TV room |
| 9/22 | Oceanview | • Started music before start of worship—well received<br>• Small group today<br>• Audience is not as consistent as at Royale<br>• Try music first again next week |
| 9/29 | Royale | • Call to worship was engaging<br>• Music was good<br>• Volunteers wanted to do the Scripture reading<br>• One person asked, "Can Jesus save?" |
| 9/29 | Oceanview | • Music was good<br>• One person disruptive and others tried to help<br>• Communion getting better |
| 10/6 | Royale | • Good response to call to worship |

| | | |
|---|---|---|
| | | • People wanted communion<br>• Latecomer wanted to make sure did not miss the bread and wine |
| 10/6 | Oceanview | • Small group<br>• Intimate discussions of the Scripture reading<br>• Some non-believers in the room<br>• One person came in and left |
| 10/13 | Royale | • Larger group today<br>• People wanted to be more involved<br>• Last praise song moved people—some had tears |
| 10/13 | Oceanview | • Smaller group<br>• Tension between residents<br>• Two people got into an argument and then asked for forgiveness<br>• Felt a push but no one behind me |
| 10/20 | Royale | • Eventful prayer requests<br>• Asking for praise song "Relentless" |
| 10/20 | Oceanview | • Smaller group<br>• Music engaging<br>• Intimate Scripture discussion<br>• One non-believer sat in the back working on a jigsaw puzzle |
| 10/27 | Royale | • Music continues to be major driver<br>• Shared Scripture reading<br>• One person asked for a Bible |
| 10/27 | Oceanview | • Small group<br>• One sat in the back just listening<br>• One sitting in the front had very cold hands |
| 11/3 | Royale | • Three people volunteered to read Scripture<br>• Interesting discussion on hypocrisy<br>• Lady came in late and prayed to the Bluetooth speaker |
| 11/3 | Oceanview | • One person asked to be "born again." |
| 11/10 | Royale | • Music was good<br>• Prayer requests robust<br>• One person walking in circles<br>• One person seemed delusional<br>• One person wanted to go home<br>• Staff asked for Eucharist. |
| 11/10 | Oceanview | • One person very quiet until the end<br>• One person wants relationship<br>• One person can't see well |

| | | <ul><li>One sat down and then left</li><li>One came late</li><li>Staff asked for Eucharist</li></ul> |
|---|---|---|
| 11/17 | Royale | <ul><li>Song requests becoming a big deal</li><li>Prayer requests continues to be strong</li><li>One person asked if you need to be baptized before receiving communion</li><li>One person very nervous and did not want communion</li><li>One person walked in circles</li><li>Staff involved and wanted Eucharist</li></ul> |
| 11/17 | Oceanview | <ul><li>Small group</li><li>People wanted to go home</li><li>Two people sat in the back, playing chess</li></ul> |
| 11/24 | Royale | <ul><li>Very receptive to music</li><li>Discussed healing relationships</li><li>Sheep narrative was a great discussion point</li></ul> |
| 11/24 | Oceanview | <ul><li>Music was well received</li><li>Volunteers read Scripture and led discussion—good exchange</li><li>Looking forward to new week</li></ul> |
| 12/1 | Royale | <ul><li>Music request "You Are God Alone"</li><li>Prayer requests around Thanksgiving</li></ul> |
| 12/1 | Oceanview | <ul><li>Music was high point</li><li>Good interactions during Scripture discussion</li></ul> |
| 12/8 | Royale | <ul><li>Few new attendees</li><li>One person came and left</li><li>One person came and said he couldn't stay</li><li>Gave out Serenity Prayer cards</li></ul> |
| 12/8 | Oceanview | <ul><li>Good interaction with residents</li><li>Music was appreciated</li><li>Switched staff</li><li>Gave out Serenity Prayer cards</li></ul> |
| 12/15 | Royale | <ul><li>New faces</li><li>Good exchange during discussions</li><li>Communion getting better</li></ul> |
| 12/15 | Oceanview | <ul><li>A few new arrivals</li><li>Looking forward to Christmas</li></ul> |
| 12/22 | Royale | <ul><li>Christmas music well received</li><li>One newcomer who seemed confused</li><li>Gave out Bibles</li><li>Christmas cards</li></ul> |

| 12/22 | Oceanview | • Christmas music well received<br>• People dancing<br>• Gave out Bibles<br>• Christmas cards |
|---|---|---|
| 12/29 | Royale | • Played more Christmas songs—well received<br>• Communion had a lot of energy<br>• Gave out New Year resolution card |
| 12/29 | Oceanview | • Christmas music well received<br>• Volunteers read Scripture<br>• A few non-believers observed<br>• Gave out New Year resolution card |

Table 5.3. Input and Comments from Staff Observations

| Item | Comment |
|---|---|
| Did the Praise Group activities contribute to supporting the goals and objectives of the facility? | • Yes. Great program. Very reliable.<br>• Yes.  In two ways. First to offer open and optional activity of the residents. Second to provide residents with an activity which has been identified by residents as a need, spiritually. |
| Did the Praise Group activities contribute to supporting individual residents or as a group? | • Yes. Patients enjoyed it and complimented it always.<br>• Individual Residents have expressed positive feedback and connection spiritually.<br>• As a group, the offered activity helps decrease overall tension or anxiety on the unit. |
| Did the Praise Group activities contribute to the spiritual wellbeing of residents? | • Yes. Patients who participated stated so.<br>• I believe so, the residents look forward to having some sort of spiritual group to help them.<br>• Residents seems to be more positive and it lifts their spirits.<br>• Always gives them encouragement and motivation.<br>• I have one patient in particular that stands out; he is a transgender male. He told me he went to your service and had the best time there. He told me about the singing (even though they were songs he didn't know, he said, he sang anyway!) and he showed me a Bible you gave him that he very much appreciated because it included beautiful pictures inside. You absolutely touched his life and made for a very positive patient experience. |
| Please provide any positive or negative feedback relative to the support provided by the Praise Group. | • We love having Paul.  He is helpful, supportive, and well liked.<br>• The residents really enjoy and appreciate the music and program you provide.<br>• They like the structure of the praise group and they are able to get communion.<br>• Music is great. |
| Are there any suggestions or recommendations going forward? | • None |

| | |
|---|---|
| | • I think you are doing a great job; the residents always look forward to Sundays and always ask "when is Paul coming back?" |

Table 5.4. Feedback and Comments from Residents

| Item | Rating<br>From 1 to 5 Scale |
|---|---|
| 1. Did the Praise Group activities support your spiritual needs? | 4.3 |
| 2. Did the Praise Group activities enable you to grow spiritually? | 4.2 |
| 3. Did the Praise Group activities contribute to your overall wellbeing? | 4.7 |
| 4. Please rate the following aspects of the Praise Group<br>  a. Music<br>  b. Sharing of Joy and Prayer Request<br>  c. Communion | <br><br>4.9<br>4.4<br>4.7 |
| 5. The Praise Group activities are creating a sense of belonging to a community | 4.6 |
| 6. In your opinion, what is the best part of the praise group? | • Sense spiritual<br>• The message<br>• Scripture<br>• Music<br>• Call to worship<br>• Jesus word<br>• Talking about God |
| 7. In your opinion, what is the worst part of the praise group? | • Forgive me<br>• None<br>• People complaining |
| 8. Are there any suggestions or recommendations going forward? | • Share thoughts<br>• More music<br>• It was great<br>• You do good already. I like the services |

Table 5.5. List of Prayer Requests

| Date | Location | Prayer Request |
|------|----------|----------------|
| 8/11 | Royale | • To be discharged<br>• Family<br>• People around you<br>• Dad<br>• Friends<br>• Want to go home |
| 8/11 | Oceanview | • Voices to go away<br>• Strength and addiction<br>• Depression<br>• Family members |
| 8/25 | Royale | • Family and friends<br>• Fiancé<br>• Challenges<br>• Good exit<br>• Nephew<br>• Recovery<br>• Stop the voices<br>• Discharge<br>• Mental illness<br>• Good grades at school<br>• Tickets to go away |
| 8/25 | Oceanview | • To be close with Jesus<br>• Family<br>• Be free |
| 9/1 | Royale | • Mom and family<br>• Be discharged<br>• Family and friends<br>• Anxiety |
| 9/1 | Oceanview | • Family<br>• Mom's health<br>• Aunt |
| 9/15 | Royale | • Mom gets saved, Dad gets cured<br>• Friend to get well<br>• Get employment |
| 9/15 | Oceanview | • Pray for health<br>• Everyone here struggling |

| | | |
|---|---|---|
| | | • Baby and PTSD of a friend |
| 9/22 | Royale | • Family and friends<br>• Mom<br>• Dad's health |
| 9/22 | Oceanview | • Companionship<br>• Grandma |
| 9/29 | Royale | • Mom colon cancer<br>• Father and marriage<br>• Stable mood<br>• Mom's property in Texas<br>• Pray for son<br>• Sobriety<br>• Daughter<br>• Dad<br>• Stress<br>• Voices and drama<br>• Police<br>• Son |
| 9/29 | Oceanview | • Healing and peace<br>• Sound mind<br>• Peace<br>• Bi-polar disorder<br>• Companionship |
| 10/6 | Royale | • Things to be better<br>• Place to stay and stability<br>• Guidance and place to stay<br>• Peace<br>• Surgery |
| 10/6 | Oceanview | • Companionship<br>• Better relationship with family<br>• Stop the pain<br>• Want to be with family |
| 10/13 | Royale | • Son<br>• People and right place to go to<br>• All my friends in Westminster<br>• Mother and relative<br>• Friend<br>• Grandmother |
| 10/13 | Oceanview | • Sanity<br>• Forgiveness<br>• Sinners |

| 10/20 | Royale | • Fiancé in Manila<br>• Mom in five years<br>• Go home soon<br>• Incest within families<br>• Return home<br>• Son-in-law<br>• Place to go to tomorrow and people there are okay<br>• Girlfriend<br>• Wife and kids |
|---|---|---|
| 10/20 | Oceanview | • Family and friends<br>• Go to a better place when discharged<br>• Want better relationships |
| 10/27 | Royale | • Dad<br>• Family<br>• Son<br>• Mom's chemo<br>• Mom<br>• Safety<br>• Friend<br>• Mom |
| 10/27 | Oceanview | • Going back to Orange County soon<br>• Be able to go home<br>• Family |
| 11/3 | Royale | • God give us love<br>• See family someday<br>• Family to contact me<br>• Family<br>• Phobia and family |
| 11/3 | Oceanview | • Board and care home<br>• Husband<br>• Salvation for the world and be humble in Christ |
| 11/10 | Royale | • Friend<br>• Son and family<br>• Relationship with mother<br>• Strength for everyone<br>• Husband and looking forward to life ahead |
| 11/10 | Oceanview | • Forgive others and love others<br>• Life partner and companionship<br>• Celebration of the world<br>• Not to be homeless again |
| 11/17 | Royale | • Friends to get healthy<br>• Health and family |

| | | |
|---|---|---|
| | | • Keep Dad busy<br>• Everyone here<br>• Mom's business to flourish<br>• Mon, Dad, and friends<br>• Personal property and belongings<br>• Wants to hear from family |
| 11/17 | Oceanview | • Mom's health<br>• All goodness<br>• Health and finances<br>• Wholesome spirit and lessons to keep hope |
| 11/24 | Royale | • Social skills<br>• Pray for health and be discharged<br>• Son and family<br>• Continue relationship with Mom |
| 11/24 | Oceanview | • Cousin getting married<br>• Stop smoking<br>• Daughter<br>• Father's health<br>• Alcohol addiction, sobriety, and people here |
| 12/1 | Royale | • Family to come and visit<br>• Back problem<br>• Discharge tomorrow<br>• Mom's chemo, cousin to come back to God<br>• Relationship with Mom<br>• Mom to be a top producer at her job<br>• Health<br>• Family<br>• Brother and son |
| 12/1 | Oceanview | • Everybody<br>• Family member<br>• Sobriety<br>• Father and sister<br>• Guidance as leaving tomorrow<br>• Ex-boyfriend and grandma |
| 12/8 | Royale | • Discharge and baby<br>• Health and discharge<br>• Quick discharge and have walks<br>• Get buddy pass<br>• Answer prayers and abundant blessings<br>• Family<br>• Go home<br>• Go home and buddy pass |

| | | |
|---|---|---|
| 12/8 | Oceanview | <ul><li>Be with family soon</li><li>Go to a safe place</li><li>Find comfort</li></ul> |
| 12/15 | Royale | <ul><li>Family and friends</li><li>Mom's relationship</li><li>Wants family to make contact</li></ul> |
| 12/15 | Oceanview | <ul><li>Thank God</li><li>Happy and successful when leaving</li><li>Come together and be blessed</li><li>Anxiety and anxiousness, seek him</li></ul> |
| 12/22 | Royale | <ul><li>Son and family</li><li>Mom and safe travel</li><li>Mom's cancer, not to get upset, be restored</li><li>Family and friends</li><li>Forgiveness of sins, family and friends, sin no more</li></ul> |
| 12/22 | Oceanview | <ul><li>Peace and strength</li><li>Mission</li><li>Peace and strength</li></ul> |
| 12/29 | Royale | <ul><li>Prayer for Dad</li><li>Brother and Mom with back problem</li><li>Mom</li></ul> |
| 12/29 | Oceanview | <ul><li>Back to Orange County and go to the Harvest</li><li>Safety and Peace</li><li>Get the right medication</li><li>Focus and keep an eye on the Lord</li></ul> |

Table 5.6. Schedule and Attendees at Worship Service

| Royale and Oceanview Schedule | | Attendance | | |
|---|---|---|---|---|
| Date | Lectionary | Royale 2 | Royale 3 | Oceanview |
| 7-Jul | | 11 | | |
| 14-Jul | | | 10 | |
| 21-Jul | | 12 | | |
| 28-Jul | | | 13 | |
| 4-Aug | | 11 | | 6 |
| 11-Aug | | | 14 | 8 |
| 18-Aug | Mt 15:10-20 or 21-28 | | | |
| 25-Aug | Mt 16:13-20 | 14 | | 6 |
| 1-Sep | Mt 16:21-28, Rom 12:9-21 | | 8 | 8 |
| 8-Sep | Mt 18:15-20 | | | |
| 15-Sep | Mt 18:21-35 | 9 | | 6 |
| 22-Sep | Mt 20:1-16 | | 11 | 6 |
| 29-Sep | Mt 21:23-32 | 12 | | 8 |
| 6-Oct | Mt 21:33-46 | | | 5 |
| 13-Oct | Mt 22:1-14 | | 14 | 4 |
| 20-Oct | Mt 22:15-22 | 12 | | 3 |
| 27-Oct | Mt 22:34-46 | | 8 | 5 |
| 3-Nov | Mt 23:1-12 | 14 | | 4 |
| 10-Nov | Mt 25:1-13 | | 6 | 4 |
| 17-Nov | Mt 25:14-30 | 11 | | 4 |
| 24-Nov | Mt 25:31-46 | | 10 | 4 |
| 1-Dec | Mt 24:36-44 | 6 | 9 | 5 |
| 8-Dec | Mt 3:1-12 | | 9 | 6 |
| 15-Dec | Mt 11:2-11 | 11 | | 7 |
| 22-Dec | Mt 1:18-25 | | 10 | 8 |
| 29-Dec | Mt 2:13-23 | 6 | | 7 |
| | Average Attendees | 11 | 10 | 6 |
| | Total | 129 | 122 | 114 |

BIBLIOGRAPHY

Abraham, R. "Mental Illness and the Ministry of the Local Church." *Pastoral Psychology* 63 (2014): 525-535. EBSCOhost.

Aist, Clark S., "The Recovery of Religious and Spiritual Significance in American Psychiatry." *Journal of Religion and Health* 51 (2012): 615-629. EBSCOhost.

Baldassare, Mark. "Tectonic Shifts in Orange County." Public Policy Institute of California. October 8, 2018. https://www.ppic.org/blog/tectonic-shifts-in-orange-county/.

Banta, J. E., and O. Mckinney. "Faith-Based Hospitals and Variation in Psychiatric Inpatient Length of Stay in California, 2002-2011." *Journal of Religion and Health* 55 (2016): 787-802. http://dx.doi.org.fuller.idm.oclc.org/10.1007/s10943-015-0175-6.

Beck, Richard. *Unclean: Meditations on Purity, Hospitality, and Mortality*. Eugene, OR: Cascade Books, 2011.

Bergamo, D., and D. White. "Frequency of Faith and Spirituality Discussion in Health Care." *Journal of Religion and Health* 55 (2016): 618-630. EBSCOhost.

Blood, Michael. "As Demographics Change in Orange County, So Do Its Politics." Associated Press. October 17, 2018. https://www.csmonitor.com/USA/Politics/2018/1017/As-demographics-change-in-Orange-County-so-do-its-politics

Branson, Mark Lau, and Juan Francisco Martinez. *Churches, Cultures and Leadership: A Practical Theology of Congregations and Ethnicities*. Downers Grove, IL: IVP Academic, 2011.

Capps, D. *Fragile Connections: Memoirs of Mental Illness for Pastoral Care Professionals.* Eugene, OR: Wipf and Stock. 2005.

_____. *Jesus the Village Psychiatrist*. Louisville, KY: Westminster John Knox Press. 2008.

_____. "The Minister and Mental Illness." *Pastoral Psychology* 63, (2014): 13-22. http://dx.doi.org.fuller.idm.oclc.org/10.1007/s11089-012-0499-z.

Carlin, Nate. "Reflections for Clinical Pastoral Education Students in Psychiatric Settings." *Journal of Religion and Health* 57 (2018): 523-537. http://dx.doi.org.fuller.idm.oclc.org/10.1007/s10943-017-0450-9.

Carlson, Dwight L. *Why Do Christians Shoot Their Wounded? Helping (Not Hurting) Those with Emotional Difficulties*. Downers Grove, IL: Intervarsity Press. 1994.

Carr, W. "Some Reflections on Spirituality, Religion, and Mental Health." *Mental Health, Religion, and Culture* 3 (2003): 2-12. EBSCOhost.

Center for Religious and Civic Culture. "California Religious Demographics: Religious Profiles of Sample California Counties." Dana and David Dornsife College of Letters, Arts, and Science, University of Southern California. April 9, 2015. https://crcc.usc.edu/california-religious-demographics/.

Coday, D. "When You're Mentally Ill, No One Brings You a Casserole." *National Catholic Reporter* 45, no. 26 (2009): 1. https://fuller.idm.oclc.org/login?url=https://search-proquest-com.fuller.idm.oclc.org/docview/215300451?accountid=11008.

County of Orange Social Services Agency. *Fiscal Year 2017-2018 Annual Report*. County of Orange Social Services Agency. Accessed November 14, 2019. http://ssa.ocgov.com/civicax/filebank/blobdload.aspx?blobid=61674.

Culpepper, R. A. "Jesus as Healer in the Gospel of Matthew, Part 1: Methodology." *In die Skriflig/ In Luce Verbi* 50, no. 1, (2016): 1-8. http://dx.doi.org.fuller.idm.oclc.org/10.4102/ids.v50i1.2115.

_____. "Jesus as Healer in the Gospel of Matthew, Part II: Jesus as Healer in Matthew 8-9." *In die Skriflig/ In Luce Verbi* 50, no. 1 (2016): 1-9. http://dx.doi.org.fuller.idm.oclc.org/10.4102/ids.v50i1.2116.

DeKraai, Mark B., Denise J. Bulling, Nancy C. Shank, and Alan J. Tomkins. "Faith-Based Organization System of Behavioral Health Care." *Journal of Psychology and Theology* 39, no. 3 (2011): 255-267. EBSCOhost.

Drane, John. *The McDonaldization of the Church: Consumer Culture and the Church's Future.* Macon, GA: Smyth and Helwys, 2000.

Everist, Norma Cook. *The Church as Learning Community: A Comprehensive Guide to Christian Education*. Nashville, TN: Abingdon Press, 2002.

Ferrell, D. R. "Jesus the Healer: A Sermon in Honor of the Memory of Donald Eric Capps (1939–2015)." *Journal of Religion and Health* 57, no. 2 (2018): 575-581. http://dx.doi.org.fuller.idm.oclc.org/10.1007/s10943-015-0164-9.

Foster-Jones, R., L. Dietzfelbingher, D. Stedman, and P. Richmond. "Including the 'Spirit' within Mental Health Care in the UK, from the Experience of People with Mental Health Problems." *Journal of Religion and Health* 57, no. 2 (2018): 384-407. EBSCOhost.

Frank, R.G., and S. A. Glied. *Better But Not Well: Mental Health Policy in the United States Since 1950.* Baltimore, MD: The Johns Hopkins University Press, 2017. Kindle.

Galanter, Marc., Helen Dermatis, Nancy Talbot, Caitlin McMahon, and Mary Jane Alexander. "Introducing Spirituality into Psychiatric Care." *Journal of Religion and Health* 50 (2011): 81-91. EBSCOhost.

Gera, Nick. "Greater Focus on Mental Health Care in OC But Progress Remains Slow." *Voice of OC*. September 21, 2016. https://voiceofoc.org/2016/09/more-focus-on-mental-health-care-in-oc-but-progress-remains-slow/.

Kehoe, Nancy C. "A Therapy Group on Spiritual Issues for Patients with Chronic Mental Illness." *Psychiatric Services* 50, no 8, (1999): 1081-1083. EBSCOhost.

_____. "Spirituality Groups in Serious Mental Illness." *Southern Medical Journal* 100, no. 6, (2007):647-648. EBSCOhost.

Koenig, Harold. *Faith and Mental Health: Religious Resources for Healing.* West Conshohocken, PA: Templeton Foundation Press, 2005.

Koenig, H., and D. B. Larson, "Religion and Mental Health: Evidence for an Association." *International Review of Psychiatry* 13, (2001): 67-78. EBSCOhost.

Kotkin, Joel. "Is the End Near for Religion?" *Orange County Register.* December 25, 2017. https://www.ocregister.com/2017/12/23/is-the-end-near-for-religion/.

Larchet, Jean-Claude. *Mental Disorder and Spiritual Healing, Teaching from the Early Christian East.* San Rafael, CA: Angelico Press. 1994.

Leavey, G., G. Dura-Vila, and M. King. "Finding Common Ground: The Boundaries and Interconnections between Faith-Based Organizations and Mental Health Services." *Mental Health, Religion, and Culture* 15, no. 4 (2012): 349-362. EBSCOhost.

Lopez, Michael. "Shortsightedness and a Continued NIMBY Culture." *Voice of OC.* June 3, 2018. https://voiceofoc.org/2018/06/lopez-shortsightedness-and-a-continued-nimby-culture/. Accessed on October 10, 2019.

Ludwig, Ashley. "Be Well Mental Health Facility Will Be First of Its Kind." *Patch.* January 29, 2019. https://patch.com/california/lakeforest-ca/be-well-mental-health-facility-will-be-first-its-kind.

Mohr, S. "Integration of Spirituality and Religion in the Care of Patients with Severe Mental Disorders." *Religions* 2, no. 4 (2011): 549-565. http://dx.doi.org.fuller.idm.oclc.org/10.3390/rel2040549.

Moltmann, Jürgen. *The Crucified God.* 40th Anniversary ed. Minneapolis, MN: Augsburg Press, 2015.

Mouton, E. "Jesus as Healer in the Gospel of Matthew: In Conversation with Alan Culpeper." *In die Skriflig/ In Luce Verbi* 50, no. 1 (2016): 1-6. http://dx.doi.org.fuller.idm.oclc.org/10.4102/ids.v50i1.2143.

Nouwen, H. *Can You Drink the Cup?* 10th Anniversary ed. Notre Dame, IL: Ave Maria Press, 2006.

_____. *The Wounded Healer: Ministry in Contemporary Society.* New York: Random House, 2013. Kindle.

"OCLinks 3 Year Anniversary: Statistics from October 2013 to October 2016." Orange County Health Care Agency. Accessed January 10, 2020. https://cms.ocgov.com/civicax/filebank/blobdload.aspx?BlobID=59970.

*Orange County Community Indicator Report 2017* Orange County Health Care Agency. Accessed October 10, 2019. http://www.ochealthiertogether.org/content/sites/ochca/Local_Reports/OC_Community_Indicators_2017.pdf.

Orange County First District. "Ending Mental Health Stigma." Accessed January 22, 2020. https://media.ocgov.com/gov/bos/1/newsletter/op_ed/ending_mental_health_stigma.asp.

Phillips III, Russell E., Rebecca Lakin, and Kenneth I. Pargament. "Brief Report: Development and Implementation of a Spiritual Issues Psychoeducational Group for those with Serious Mental Illness." *Community Mental Health Journal* 38, no. 6 (2002): 487-494. EBSCOhost.

Pohl, Christine. *Making Room: Recovering Hospitality as a Christian Tradition.* Grand Rapids, MI: Eerdmans, 1999. Kindle.

Replogle, Jill. "Is Orange County Turning the Corner on Homelessness? 89.3 KPCC. March 5, 2018. https://www.scpr.org/news/2018/03/05/81292/is-orange-county-turning-the-corner-on-homelessnes/.

Revheim, Nadine and William M. Greenberg. "Spirituality Matters: Creating a Time and Place for Hope." *Psychiatric Rehabilitation Journal* 30, no. 4, (2007): 307-310. EBSCOhost.

Roberts-Lewis, A., and T. D. Armstrong. "Moving the Church to Social Action." *Social Work and Christianity* 37, no. 2 (2010): 115-127. https://fuller.idm.oclc.org/login?url=https://search-proquest com.fuller.idm.oclc.org/docview/517881229?accountid=11008.

Simpson, Amy. "Supporting Families Living with Mental Illness." *The Covenant Quarterly* 73, no. 3/4 (Aug/Nov 2015): 40-53. EBSCOhost.

_____. *Troubled Mind: Mental Illness and the Church's Mission*. Downers Grove, IL: InterVarsity Press. 2013.

Stanford, M. "Demon or Disorder: A Survey of Attitudes toward Mental Illness in the Christian Church." *Mental Health, Religion, and Culture* 10, no. 5 (September 2007): 445-449. EBSCOhost.

Stanley, J. "Night and Inner Light: A Quaker Model of Pastoral Care for the Mentally Ill." *Journal of Religion and Health* 49 (2010): 547-559. EBSCOhost.

Sullivan, S., J. M. Pyne, A. M. Cheney, J. Hunt, T. F. Haynes, and G. Sullivan. "The Pew Versus the Couch: Relationship Between Mental Health and Faith Communities and Lessons Learned from a VA/Clergy Partnership Project." *Journal of Religion and Health* 53, no. 4 (2014): 1267-82. https://dx.doi.org.fuller.idm.oclc.org/10.1007/s10943-013-9731-0.

Torrey, F. E. *American Psychosis: How the Federal Government Destroyed the Mental Illness Treatment System*. New York: Oxford University Press, 2014. Kindle.

Vanier, Jean. *Becoming Human*. Mahwah, NJ: Paulist Press,1998.

_____. *Community and Growth*. Exeter, UK. Short Run Press. 2007.

_____. *From Brokenness to Community*. Mahwah, NJ; Paulist Press, 1992.

Wall, Benjamin, S. *Welcome as a Way of Life. A Practical Theology of Jean Vanier*. Eugene, OR: Cascade Books, 2016.

Webb, M., A. Charbonneau, R. McCann, and K. Gayle. "Struggling and Enduring with God, Religious Support, and Recovery from Severe Mental Illness." *Journal of Clinical Psychology* 67, no. 12 (2011): 1161-1176. EBSCOhost.

Weisman de Mamani, Amy G., Naomi Tuchman, and Eugenio Duarte. "Incorporating Religion/Spirituality into Treatment for Serious Mental Illness." *Cognitive and Behavioral Practice* 17 (2010): 348-357. EBSCOhost.

Wiener, Jocelyn. "All Too Often, California's Default Mental Institutions Are Now Jails and Prisons." *Cal Matters*. February 4, 2019. https://calmatters.org/projects/california-mental-health-treatment-in-prisons/.

Wong-McDonald, Ana. "Spirituality and Psychosocial Rehabilitation: Empowering Persons with Serious Psychiatric Disabilities at an Inner-City Community Program" *Psychiatric Rehabilitation Journal* 30, no. 4 (2007): 295-300. EBSCOhost.