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Consumers, clergy, and clinicians in collaboration: Ongoing implementation and evaluation of a mental wellness program

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ABSTRACT

As a foundation of most cultures, with roots in persons' early development, religion can be a source of hope as well as denigration. Some religious institutions have made attempts to help persons with mental health problems, and some mental health professionals have sought to engage religion resources. These programs have rarely been sustained. In 2008, the Mental Health Center of Denver (MHCD) developed a program to assess the utility of religion resources within mental health care. In response to positive feedback, MHCD appointed a director of Faith and Spiritual Wellness who facilitates community outreach to faith communities and spiritual integration training to MHCD staff. This director initiated a Clergy Outreach & Professional Engagement (COPE) conference for consumers, clergy, and clinicians. The goal was to acknowledge borders between parts of persons' lives, and to build bridges of collaboration to facilitate care. Participants described lived examples of collaboration to improve mental wellness, including the need for a "solid welcome" from congregations. Subsequent, online surveys generated quantitative data on the usefulness of the conference to encourage and to generate ideas for interaction. Each group affirmed the utility of the conference; consumers and clinicians found the conference more useful than clergy. Qualitative assessment confirmed that across culture differences, participants found common language to demonstrate that persons of different traditions can provide care inclusive of religious resources. This assessment concludes with recommendations for future collaboration, led by consumer input, to expand recovery networks.

KEYWORDS

Clergy; collaboration; community based participatory research; community integration; generative imperative; generativity; mental health; prevention science; recovery; religion; spirituality; well-being; wellness

Religion, as a foundation of most cultures, exists in most persons' lives from their first day. With roots in people's early development, religion can be a powerful source of hope and affirmation, as well as rejection and denigration (Beit-Hallahmi, 2015; Fowler, 1981; Geertz, 1973, 2000; Milstein & Manierre, 2012; Pargament & Lomax, 2013). From a prevention science perspective, some religious communities can increase the risks for mental and emotional

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distress, whereas other religious congregations can be a foundation of support that prevents the need for clinical care, serve as a bridge to care, and also be a part of an individual's recovery process (Gordon, Steinberg, & Silverman, 1987; Milstein, Manierre, & Yali, 2010; Nieuwsma et al., 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2004).

The purpose of this article is to describe the preparation, implementation, and evaluation of an initiative to facilitate collaboration between consumers, clergy, and clinicians to enable wellness and well-being (Rath & Harter, 2010). It concludes with recommendations for how consumers may guide future collaborations that both acknowledge the borders between clinical care and religious practice, as well as bridge these parts of peoples' lives to improve care and recovery and wellness.

Across centuries, some religious institutions have persecuted persons with mental illness (Ellinger, 1874; Hinshaw, 2007; Pruyser, 1966), whereas others have made attempts to help persons with emotional and mental health problems (Earle, 1851/1994; Goldstein & Godemont, 2003; Hinshaw, 2007; Pruyser, 1966; Sano, 1932). With the advent of psychiatry, later psychology, and then social work, some of these professionals sought to engage the resources of clergy and their congregations to improve the continuity of mental health care. Over many decades, initiatives to facilitate collaboration between clergy and mental health clinicians were developed (American Public Health Association, 1946; Fallot, 1998; Levenberg, 1976; McCann, 1962; McMinn, Chaddock, Edwards, Lim, & Campbell, 1998; Milstein, Manierre, Susman, & Bruce, 2008; Stanford, 1819/1847). Typically, these were and remain top-down treatment—rather than recovery—models, dependent on professionals reaching out to one another, to build a plan for consumers with mental health needs, with little input from these consumers (Corin & Lauzon, 1992; Davidson, 2003; Milstein et al., 2010). Few have evaluated the efficacy of these outreach programs (Singh, Shah, Gupta, Coverdale, & Harris, 2012).

There are multiple obstacles to clergy and clinician collaboration (Sullivan et al., 2014). Some mental health professionals and clergy assert that mental health care and religion can pose a risk to one another (Bobgan & Bobgan, 2012; Sloan et al., 2000; Vitz, 1994). Others find no common ground in their work: neither common knowledge of one another, nor a professional relationship on which to build collaborations (Sullivan et al., 2014; Weaver, Flannelly, Flannelly, & Oppenheimer, 2003). Even when there is an interest in cooperation, there are few work settings that acknowledge and support collaboration to improve mental health care within the clergy's or clinician's "billable hours" (Milstein et al., 2005; Nieuwsma et al., 2013).

Stigma further impedes collaboration (Corrigan, 2004; Link & Phelan, 2001). Two ways people with mental and emotional difficulties experience stigma in relation to religious and spiritual beliefs and practices are (1) In their own communities, people believe they will be judged and rejected by

their fellow congregants and therefore keep silent about any mental health problem or treatment (Corrigan, Larson, & Rüsck, 2009). Consumers have reported that their own clergy discouraged them from seeking mental health care and exhorted them only to pray harder (Shifrin, 1998; Spencer, 2009); (2) In treatment, people report that they hesitate to discuss their personal religiosity with their clinicians as they have encountered mental health professionals who are neither curious about, nor supportive of, the role of religion and spirituality in their lives. Consumers have said that their mental health professionals have discouraged their participation in religious activities (Substance Abuse and Mental Health Services Administration, 2004). Even with these stigmas, persons with serious mental illness seek help from clergy more often than from clinicians (Smolak et al., 2013; Wang, Berglund, & Kessler, 2003), and their religious beliefs influence how they interact with clinicians (Borras et al., 2007).

In recent years, initiatives by mental health consumers, as well as by clinicians and researchers, and by the SAMHSA, have moved discussions of mental health care away from symptom management toward recovery and well-being (The Icarus Project, 2013; McNamara & DuBrul, 2013; Nelson, Lord, & Ochocka, 2001; Rath & Harter, 2010; Substance Abuse and Mental Health Services Administration, 2011). Rather than depending on the guidance of professionals, wellness is guided by individuals who integrate professional clinical care into their personal thriving (Davidson, Tondora, & Ridgway, 2010). Beyond clinical care, individuals thrive through social engagement, which for many includes communities of spiritual/religious affiliation (Cacioppo, Capitano, & Cacioppo, 2014; Krause & Hayward, 2015; Milstein et al., 2010; Pargament, 2007; Sells et al., 2006). One study of persons with serious mental illness found that though over three fourths (77.6%) considered going to a place of worship important, more than one half (58.9%) went less than desired (Salzer, Brusilovskiy, Prvu-Bettger, & Kottsieper, 2014).

The enactment of mental health care built for recovery requires cultural competence on the part of clinicians in order to assess the broad strengths of the whole person, and SAMHSA has identified spirituality as one of these strengths in its eight dimensions of wellness (Dunn, 1961; Swarbrick, 2006; Swarbrick & Brice, 2006). Successful enactment will also require assertive self-representation by mental health consumers to integrate their care within the breadth of their living and to communicate their personal spiritual views and religious practice (Davidson, Ridgway, Wieland, & O'Connell, 2009). One characteristic, associated with low rates of hospitalization among people with schizophrenia, is religious activity, and another is the importance of religion to their personal stories and social contexts (Corin & Lauzon, 1992, 1994; Davidson, 2003).

This project was built upon prevention science and community-based participatory research (CBPR) models to facilitate sustainable collaboration

between consumers, clergy, and clinicians (Barry & Edgman-Levitan, 2012; Mrazek & Haggerty, 1994). This project proposes:

that clergy (with their discrete expert knowledge about religion) and clinicians (with their discrete expert knowledge about mental health care) can better help a broader array of persons with emotional difficulties and disorders through professional collaboration than they can by working alone. (Milstein et al., 2008, p. 220)

To guide such ongoing professional collaboration we seek to build a program with direct input by persons who use mental health care (consumers), and follow the CBPR principle, “nothing about me without me” (Delbanco et al., 2001, p. 145).

The next sections describe the development, enactment and evaluation of a CBPR program— centered on an inclusive half-day conference— to improve consumer, clergy and clinician collaboration. The goal was to first acknowledge the borders between parts of persons’ lives, and then to build bridges of collaboration to facilitate care, recovery, and wellness.

Background of the program

In 2008, the Mental Health Center of Denver (MHCD) began a new initiative to assess the roles of spirituality and religion in the lives of mental health care consumers (Mason et al., 2004). These assessments led MHCD to develop and coordinate programming inclusive of religious and spiritual resources. In 2011 MHCD created the position “director of Faith and Spiritual Wellness.”

One role of the director is to implement an outreach program to communicate with religious communities in the Metropolitan Denver Area, to assess their willingness and capacity to work with persons with mental and emotional difficulties, as well as to determine if religious congregations would be open to receiving training on how to help persons with mental health difficulties. A second role of the director is to conduct “inreach” training for MHCD clinicians on how to include religion and spirituality in client assessment and treatment planning (Anandarajah & Hight, 2001; Milstein et al., 2008; Puchalski, 2006). This program was aligned with MHCD’s transition from a focus on illness management to their new emphasis on client-centered well-being (Corin & Harnois, 1991; Rath & Harter, 2010).

Through outreach and inreach initiatives, the MHCD director of Faith and Spiritual Wellness identified programs in the Metropolitan Denver Area, as well as national organizations, that strive to connect religious resources to mental health care. Below is a partial list of these resources:

Metropolitan Denver resources

- The Samaritan Institute (<http://www.samaritaninstitute.org>): National network of outpatient programs employ licensed counselors trained in both

theology and psychology. The centers often locate their clinic offices in local churches.

- Centus Counseling, Consulting, and Education (<https://centus.org>): A local network accredited by The Samaritan Institute. Each counselor also works with the pastor of his or her host congregation to consult on mental health issues with staff.
- Stephen Ministries (<http://www.stephenministries.org>): An explicitly Christian lay program that trains members of congregations both as empathic listeners, as well as to make referrals to mental health professionals.
- Interfaith Network on Mental Illness (INMI) (Boulder) (<http://www.inmi.us/index.html>): Facilitates understanding of mental illness among clergy, staff and lay leaders. Sponsors the Caring Clergy website (<http://www.caringclergyproject.org/>), and Interfaith Directory (<http://www.inmi.us/fwconn.html>).
- Iliff School of Theology Iliff offers a Master of Arts in Pastoral and Spiritual Care (MAPSC) that can be combined with the Master of Arts in Social Work through the University of Denver (<http://www.iliff.edu/degrees-certificates/degree-programs/master-of-arts-in-pastoral-and-spiritual-care-mapsc>).

National resources

Several national organizations and denominations have programs designed to educate members as well as to reach out to persons who have experienced mental health problems:

- American Psychiatric Association (<http://www.psychiatry.org/faith>)
- American Psychological Association (<https://www.apa.org/about/policy/religious-discrimination.pdf>)
- Nathan Kline Institute for Psychiatric Research (<http://ssrdqst.rfmh.org/cecc>)
- National Alliance On Mental Illness Faith Net (www.nami.org/namifaithnet)
- Pathways to Promise Interfaith Ministries (www.pathways2promise.org)
- Mental Health Ministries (www.mentalhealthministries.net)
- U.S. Dept. of Veterans Affairs Mental Health and Chaplaincy Learning Collaborative (http://www.mirecc.va.gov/mentalhealthandchaplaincy/Learning_Collaborative.asp)
- Islam (<http://www.muslimmentalhealth.com/mmh/>)
- Judaism (<http://www.ujafedny.org/what-we-do/help-people-in-need/shabbat-of-wholeness/>)
 - Reform (<http://www.rac.org/position-reform-movement-mental-health>)
 - Orthodox (<http://www.nefesh.org/about.cfm>)
- National Catholic Partnership on Disability (www.ncpd.org)

- Presbyterian Church U.S.A. (Presbyterian Church, 2008) (<https://www.pcusa.org/resource/comfort-my-people-policy-statement-serious-mental-/>)
- Saddleback Church (<http://saddleback.com/connect/ministry/mental-health-ministry/lake-forest>)
- Unitarian Universalist Mental Health Ministry (www.mpuuc.org/mentalhealth)
- United Methodist Ministries (<http://www.umc.org/what-we-believe/ministries-in-mental-illness>).

Development and promotion of the conference

This research project was a paradigm of CBPR as it was initiated by the MHCD in response to the expressed needs of their staff, consumers, and faith communities (Campbell et al., 2007). First, MHCD determined—through their own director of Faith and Spiritual Wellness—that they would benefit from a meeting bringing consumers, clergy, and clinicians together. Only then, upon understanding the goals of the three groups, did they seek consultation from an experienced academic researcher to design and measure the utility of interventions to respond to MHCD’s community-determined needs. The conference was designed to be a comprehensive meeting, acknowledging that the challenges of mental/emotional problems are made more difficult when stigma impedes individuals’ access to mental health care and/or religious and spiritual involvement (Davidson, 2003; Link & Phelan, 2001; Milstein et al., 2005).

This program was organized by a local mental health center that sought to expand its infrastructure and create new and sustainable protocols of care. Another exceptional aspect of this program is that the MHCD has a history of planned growth to provide integrated and collaborative care for persons with serious and persistent mental illness.

The name of the conference was “Lives Well Lived” and promoted as “A conference to discuss pathways of recovery, wellness and thriving created and nurtured through collaboration between consumers, faith communities and clinicians.” To achieve relevant community participation (Ammerman et al., 2003; O’Toole, Aaron, Chin, Horowitz, & Tyson, 2003), conference organizers invited all consumers affiliated with MHCD, as well as all clinicians affiliated with MHCD and three other community mental health organizations. The invitation list included clergy from all of the 26 Catholic, Protestant, and Jewish denominations with whom the director of Faith and Spiritual Wellness had conducted community outreach and training. Invitations were sent to 150 persons, proportionally divided between consumers (20%), clergy (45%), and clinicians (35%).

Ninety individuals attended the conference. At registration, participants were not asked to identify if they were consumer, clergy, or clinician. As

the subsequent dialogues demonstrated, many participants self-identify as pertaining to multiple categories. A review by the director of the list of attendees showed clergy from 13 Protestant denominations and 1 Jewish denomination.

The conference

The planning committee developed a three-part, half-day program: Keynote Speech, three Panel Presentations (on each panel: consumer, clergy, and clinician), and Roundtable Discussions among participants. The Keynote Speech and the Panel Presentations were videotaped to provide verbatim quotes, as well as to be analyzed qualitatively. Below is a description of each part of the conference:

Keynote Speech

The Keynote Speech was titled “Sea Turtles, Moon Landings, Lives Well Lived” and lasted one hour. The first observation of the talk was the interconnected affiliation of humanity, mediated by culture (Bruner, 1990; Erikson & Erikson, 1997; Milstein & Manierre, 2012). A second observation was how for most of humanity, religion is a foundation of culture (Atran & Norenzayan, 2004; Freud, 1930; Geertz, 1973, 2000; Schaller, Norenzayan, Heine, Yamagishi, & Kameda, 2010), and an organizing element of identity formation across most human lifespans (Darwin, 1871; Erikson, 1966; Fowler, 1981; Zock, 2004). The second observation was that to be culturally competent, as well as to assess the breadth of persons’ experiences, and to then provide a continuum of care directed toward recovery and wellness, it is necessary—where salient—to acknowledge and integrate religion needs into a recovery trajectory (Milstein et al., 2010; Sells et al., 2006; Smolak et al., 2013). A third part of the presentation was a description of the prevention science-based model of Clergy Outreach & Professional Engagement (COPE) (Figure 1), with its application to the continuum of mental health care, recovery and community reengagement. COPE is derived from the National Institute of Mental Health four-part taxonomy of mental illness prevention: (1) Universal, (2) Selective, (3) Integrated, and (4) Relapse (Gordon, 1983; Milstein et al., 2008; Mrazek & Haggerty, 1994; National Advisory Mental Health Council Workgroup on Mental Disorders Prevention Research, 2001).

The COPE model is an analogous four-category pathway of a cycle of care, leading from (1) wellness to (2) significant stress through (3) dysfunction to (4) recovery and back to wellness (Figure 1). The COPE model elucidates when it is recommended for clergy to seek consultation from clinicians to assess a congregant’s level of stress to determine if there is a level of dysfunction that



Figure 1. Clergy Outreach & Professional Engagement (COPE): A Continuum of Care and Recovery.

would benefit from clinical care (from 2 to 3), as well as when a clinician would consult with clergy to engage the breadth of an individual’s social and community and spiritual support to facilitate and strengthen the person’s recovery (from 3 to 4). The effectiveness of social support and treatment and recovery also requires that the individual consumer of care be able to guide the process along the continuum (Corin & Harnois, 1991; Davidson et al., 2009; Davidson, Shaw, et al., 2010). The COPE model provides guideposts and guidelines to enact these collaborations to sustain recovery and facilitate well-being across these borders by building bridges (Figure 1).

To understand the role of religious communities in universal wellness (Figure 1), the Keynote Speech described what Erik Erikson termed “generativity” the developmental task of the adult to strengthen the world for the next generation (de St. Aubin, McAdams, & Kim, 2004; Erikson & Erikson, 1997). For most people this generativity requires participation in a family and a community. Frequently, stigma and self-isolation keep persons with mental health difficulties from participating in their communities as generative adults (Corrigan, 2004; Corrigan et al., 2009). For others, they prefer to interact with community at first from a distance, a “positive withdrawal,” as they determine their own comfort (Corin, 1990; Corin & Lauzon, 1992, 1994). As Erikson explains in his theory, the first task is to achieve a sense of hope, that strengthens lives and validates self-acceptance, and to then interact with others (Brown, 2006; Corin & Lauzon, 1992; Erikson & Erikson, 1997; Kellam, Branch, Agrawal, & Ensminger, 1975).

Religious communities can serve as de facto generativity centers: they strengthen communities through festivities and rituals, education programs, and social justice activities. For persons who have experienced mental illness and also seek a religious community, it is necessary for them to seek a community where they are welcome—either welcomed back

or welcomed anew. Clinicians (Milstein & Manierre, 2012) or peers (Salzer, Schwenk, & Brusilovskiy, 2010; Swarbrick, 2006) may play a role in helping the individual to successfully navigate this search for a welcoming religious community.

The keynote speaker, a clinical psychologist, concluded by noting that clinicians are paid to strengthen the self-direction of consumers' lives. Therefore one sign of clinical success is manifest in those clients who finish therapy and then independently, "journey outside of our offices, our clinics, and our hospitals ... to their own church, synagogue, mosque, temple, or other sanctified places of rituals filled with diverse, personal, ineffable mysteries" (Milstein et al., 2010, p. 379).

Panel presentations

Through the leadership and community relationships of the conference organizers, three panels were formed to lead this section of the conference. Each panel had a consumer, a clergy person, and a clinician with a history of collaboration. The stories and ideas shared by the panelists provided lived examples of concepts discussed in mental health literature, and policy initiatives on the inclusion of religious or spiritual beliefs and practices in care and recovery (American Public Health Association, 1946; Bledsoe, Setterlund, Adams, Fok-Trela, & Connolly, 2013; Farrell & Goibert, 2008; Nieuwsma et al., 2013; Substance Abuse and Mental Health Services Administration, 2004). In a qualitative analysis of the panelists videotaped comments, three vital themes emerged (Strauss & Corbin, 1998): (1) personal meaning/value, (2) spiritual connection, and (3) community participation. Below is a review of each theme, with verbatim quotes where salient.

Personal meaning/value

The foundational theme to which the panelists frequently returned was the manner in which religious beliefs can imbue each individual with a sense of unique value. Panelists described how the starting point for recovery came with the belief that each individual matters, including oneself (see the example of Marsha Linehan, PhD in Carey, 2011). Consistent with Erikson's theory, the first step in recovery was an internal sense of hope (Erikson, 1977; Zock, 2004). For these panelists, religion and spirituality provide them with a personal source of hope and existential meaning, leading them to seek community. One panelist expressed this paradigm with, "God does not make junk."

Spiritual ritual and connection

From the panelists' discussions of belief in one's unique value came descriptions of spiritual connections and spiritual coherence (Figure 1). These

included rituals practiced, rituals remembered, and a connection to expressions of religious faith, which provided a source of ongoing meaning and purpose. For several panelists, one's own prayer, as well as the prayers of others, were their robust, unique lifeline and refuge in moments of fear and hopelessness. These connections parallel the connection to community that Fowler— following Erikson – identified as the “interpersonal self” (Erikson, 1977; Fowler, 1981; Hoare, 2002).

One panelist, a minister whose son has suffered from bipolar disorder and substance abuse, described a near-sleepless night looking for his son on the streets of New York City. This minister had exhausted any possibility of further searching, or contacting authorities. He was physically, as well as emotionally, depleted and in need of sleep that would not come. He called a friend— whom he describes as a “prayer warrior.” She told him that she and others would pray for his son. For this father, knowing persons were praying for his son gave him the solace that brought him sleep. This was community support, which provided the comfort of a spiritual coherence independent of clinical interventions (Figure 1).

Another panelist, a clinical psychologist, described the role of religion in helping the course of therapy. She said that in her experience if someone had a religious tradition and positive religious experience, that gave the therapy a foundation from early development to reclaim over time. This psychologist said that she had learned from her religious patients to add three questions to her assessment of each new client: (1) “Do you have a faith? (2) Do you have a set of beliefs that are comforting to you? and (3) Do you have a community that's comforting to you?” (also see Figure 2).

1. Do you have a sense of *belonging*?
 - Where?
 - Who?

2. Do you have a sense of *purpose*?
 - Meaningfulness?
 - Accomplishment?

3. Do you have a sense of *sacredness*?
 - Preciousness of life?
 - Connection to the natural world?

4. Do you have *trust*?
 - Of other people?
 - Of life's continuance?
 - Hope?

Figure 2. Spiritual resource assessment. Adapted with permission from a presentation by Jed Shapiro, MD.

Community participation

Along with a sense of individual value and individual acts of faith, the panel also explained the importance of religion and spirituality in guiding them toward more active community participation. One panelist described her spiritual journey from an early childhood spent in the church, to a departure as an adolescent and a return as an adult. She began by describing how the rhythms of her youth included weekly church attendance, which she liked. Then, she said:

I rejected the church after I learned about the Holocaust and asked my minister if the Jews who were murdered would go to heaven. He told me that if they didn't believe in Jesus, they weren't going to heaven and that made me move away from the church.

Years later this panelist was diagnosed with bipolar disorder. This led to disruptions in her family and professional life. For some time she withdrew from contact with others. From self-isolation she formed a group with other persons who had experienced mental illness. She told the conference that for a number of years she found spirituality in the community of the group she had formed and in the beauty of nature in Colorado (Flaskerud, 2014). Eventually she made her way to a nondenominational, “trans-spiritual” church dialogue group.

The positive experience of this second group motivated her to attend services at the church where— for the first time— she received what she named a “solid welcome” from a religious congregation. It is important to note that the strength this panelist built and nurtured to rejoin community did not come via a clinician or a clergy person. Her strength came from cultivating a “positive withdrawal” (Corin & Lauzon, 1994; Davidson, 2003), that led to a personal spiritual path. When she was ready to return to community, she searched until she found a “solid welcome” from the church she chose to attend. This “solid welcome” was found in a warm greeting and also through institutional and ritual decisions made by that church. As an institutional priority, the church sponsors, “a Second Sunday series on mental health.” What the panelist described as “really important” to her was a ritual decision by the church; she noted that, “when the minister includes those with mental illness and brain disorders in the Prayers for the People it really touches me and makes me feel even more a part of the community.” The panelist's experience is consistent with research on the positive effects of a self-integrated religiosity as compared to an externally imposed religiosity (Pargament, 2002).

A clinical psychologist panelist, who described herself as, “not a Christian counselor” because, “I do not use Christian, or religious or biblical principles in my work,” observed that as therapy is successful, the consumer's focus turns from inward to outward. Religious congregations provide her clients an opportunity to be an active, generative member of a community. It helps to fulfill what we have termed the “*Generative Imperative*” to contribute to society in the service of subsequent generations.

Panels' conclusions

Although each member of every panel spoke, it was the consumers who provided the integrated narratives of difficulties and recoveries. Panelists described moments of desolate isolation, as well as journeys back to self-efficacy and community. As in all development across the stages of the human life span, these journeys combined a process of establishing self-worth, followed by a sense of community identification, leading to generative community membership (Fowler, 1981; Milstein & Manierre, 2012; Ochse & Plug, 1986).

From the nine panelists' observations, one can determine that to achieve this inclusion, there are separate sets of challenges for (1) clinicians, (2) clergy, and (3) consumers.

Clinicians. Their challenge is to actively inquire about the religious/spiritual beliefs, practices, and resources of their clients. One clinician, a psychiatrist, proffered the assessment procedure he uses to distinguish whether spirituality is as an asset or a negative variable (Figure 2). Participants were reminded that numerous spiritual assessment tools are available (Anandarajah & Hight, 2001; Pargament, 2007; Puchalski, 2006). One paradigmatic assessment question asks, "Have you ever had a time in your life when you felt deeply and fully alive?" (Pargament, 2007, p. 216).

Clergy and congregations. Their challenge is to provide a "solid welcome" to persons with mental and emotional difficulties. Such a welcome will encourage persons to fully participate in congregational life. Such clergy and congregations will also listen to, and learn from, consumers' hard-earned wisdom, and will support persons' decisions to seek the professional mental health care they need.

Consumers. Their challenge is to believe in— as well as advocate for— their own wholeness. It is up to consumers to educate their clinicians about the importance of spiritually-inclusive therapy (Milstein et al., 2005; Milstein & Manierre, 2012) and hold clergy to their obligation to live their faith in supportive action. One consumer panelist described the spirituality of being in community, "For me, spirituality was defined by that phrase, 'Faith without works is dead.' (paraphrase of James, 2:17). Because I felt that I was showing my faith by working with other people."

Roundtable discussions

After the panel presentations, participants were asked to converse with the five to nine people seated with them at their tables. Their assignment was to list three actions for "going forward." All persons were asked to introduce themselves and to describe which actions they could facilitate: at their workplace as clinicians, in their congregations as clergy, or in their communities as

consumers. Table discussions revealed a depth and breadth of knowledge and experience: several tables spoke of actions as community volunteers. Several clinicians learned for the first time about programs at other local agencies and religious congregations.

A follow-up e-mail interview (described in detail below) provided a wide variety of Roundtable Discussions participant responses. One hindrance to the Roundtable Discussions was that it was at the same time as the buffet-style lunch. As a result, for several persons, it was difficult to get acquainted as well as structure a conversation while getting in line for lunch. Yet for others, the Roundtable Discussions were the highlight of the conference, “because of the personal nature of small group conversations.”

Evaluation of the conference from participant surveys

The planning group sought to create a conference that would build bridges of knowledge and collaborative action across consumers, clergy, and clinicians to improve treatment and wellness. As an initial conference, the planning group determined three standards for their metrics of success: (1) a minimum standard of success if participants reported that the conference was useful, (2) a median standard of success if participants felt supported and validated in their efforts to incorporate religion and spirituality into mental health, and (3) an optimum standard of success if the participants used the conference to build an inclusive or collaborative mental health action plan.

Two weeks after the conference, an e-mail was sent to all 90 participants. They were asked to take an anonymous online survey to report on their experience at the conference. A follow-up e-mail was sent 3 months later and in all 53 participants (59%) answered the survey. Some persons identified themselves as pertaining to more than one category and provided answers in multiple categories resulting in 59 respondents overall.

Quantitative analysis

The goal of the conference was to initiate and support ongoing efforts of collaboration between consumers, clergy, and clinicians. To quantitatively evaluate the success of these efforts, participants' answered questions with an 8-point Likert-type scale. Appraisals of the conference were measured through answers to three broad questions, representing the minimum, median, and optimum standard of success: (1) Was the conference useful overall, as well as were the Keynote Speech, the Panel Presentations, and Roundtable Discussions each useful to the participants? (1 = *not useful* to 8 = *very useful*); (2) Did the participants feel supported and validated in their work facilitating collaboration efforts between consumers, clergy, and clinicians? (1 = *not supported* to 8 = *supported*); (3) Did the participants identify

Table 1. Participant feedback.

Question:	Consumers (n = 19)		Clergy (n = 14)		Clinicians (n = 26)	
	M	SD	M	SD	M	SD
1. Useful?						
Conference overall	7.38	.72	6.82	.98	7.39	.66
>Keynote Speech	7.47	.61	6.64	.93	7.16	.85
>Panel Presentations	7.21	1.18	6.57	1.28	7.15	1.16
>Roundtable Discussions	6.11	2.27	5.46	1.81	6.92	1.5
2. Supported/validated?	7.35	1.06	7.27	1.01	7.30	.97
3. Action plan?	5.00	2.27	5.00	1.94	5.64	2.06

a specific action plan for next steps of collaboration? (1 = *not identified* to 8 = *identified*). There was room for comments after each question. Table 1 summarizes the quantitative results. Factorial ANOVA tests were conducted to characterize appraisal differences in satisfaction across participants based on mean values from Table 1. Assumptions underlying the ANOVA model were assessed, and results verified with nonparametric analogues or data transformations.

Overall response to the conference

A two-way ANOVA yielded a significant main effect for participants' appraisal of the conference with a large effect size, $F(2, 137) = 30.848, p = .000, \eta_p^2 = .311$ (Figure 3). The average rating of the extent to which participants identified an action plan from the conference ($M = 5.21, SE = .217$) was lower than the average rating for the extent to which participants felt supported/validated ($M = 7.31, SE = .202$) or felt the conference was useful ($M = 7.20, SE = .204$). The difference in average rating between the usefulness and validation of the conference was not statistically significant. Pairwise comparisons were adjusted using the Bonferroni correction. The two-way ANOVA did not yield a significant main effect for the participant group, $F(2, 137) = 1.02,$

**Figure 3.** Three metrics of conference success evaluated by each type of participant.

$p = .365$, meaning that average ratings over the three categories were not statistically different between consumers ($M = 6.58$, $SE = .205$), clinicians ($M = 6.78$, $SE = .167$), or clergy participants ($M = 6.36$, $SE = .244$).

Usefulness

A one-way ANOVA did not yield a statistical difference in the mean response for the overall usefulness of the conference across the three groups of participants (consumers, clinicians and clergy) did not yield a significant difference, $F(2, 47) = 2.41$, $p = .100$. Due to lack of normality, assessed with the Kolmogorov-Smirnov test, for two of the three groups: consumers, $D(16) = .31$, $p = .00$, clinicians, $D(23) = .30$, $p = .00$, and clergy, $D(11) = .21$, $p = .19$, we conducted a Kruskal-Wallis equality of populations rank test. The results confirm the ANOVA findings, $H(2) = 3.35$, $p = .187$.

Supported/validated

A one-way ANOVA yielded no statistical difference in the mean response for the question asking participants to state the extent to which they felt supported/validated by the conference, $F(2, 48) = .023$, $p = .977$. Although the equal variances assumption was satisfied, $F(2, 48) = .012$, $p = .988$, the normality assumption of the errors was not. Specifically, the Kolmogorov-Smirnov test for consumer, clinician and clergy groups indicate the normality assumption does not hold ($D = 0.318$, $df = 17$, $p = .00$; $D = .328$, $df = 23$, $p = .00$; $D = .310$, $df = 11$, $p = .004$, respectively). We therefore, confirmed these results by conducting a Kruskal-Wallis test. According to this test, differences in the mean rank across groups were not statistically significant ($H = .096$, $df = 2$, $p = .953$).

Action plan

A one-way ANOVA yielded no statistical difference in the mean response for the question asking participants to state the extent to which they were able to identify an action plan for next steps of collaboration with clergy, consumers and clinicians, $F(2, 42) = .517$, $p = .600$. Although the equal variances assumption was satisfied, $F(2, 42) = .831$, $p = .443$, a Kolmogorov-Smirnov test shows the normality assumption of the errors was not satisfied for the clinician group ($D = .246$, $df = 22$, $p = .000$). We therefore, confirmed these results by conducting a Kruskal-Wallis test. According to this test, differences in the mean rank across groups were not statistically significant ($H = 1.340$, $df = 22$, $p = .512$).

Figure 4 shows the usefulness of each part of the conference (Keynote, Panel Presentations, Roundtable Discussions) as judged by each type of participant (consumer, clergy, clinician). The participants' affirmed the usefulness of the Keynote Speech ($M = 7.09$, $SE = .180$), as well as the Panel Presentations ($M = 7.02$, $SE = .179$). A two-way ANOVA yielded a significant

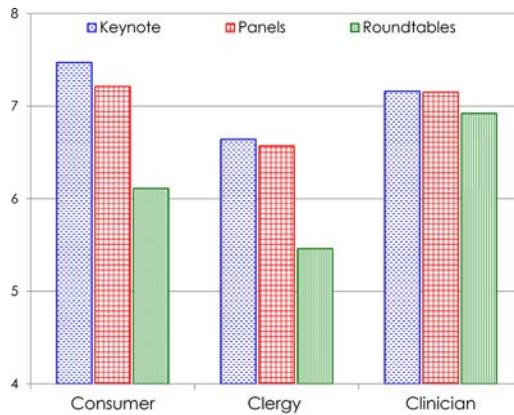


Figure 4. Usefulness of each part of the conference evaluated by each type of participant.

main effect for the event, $F(2, 161) = 7.99, p = .000, \eta_p = .090$) with usefulness of the Roundtable Discussions ($M = 6.12, SE = .185$) as significantly lower than either the Keynote Speech ($p = .001$) or the Panel Presentations ($p = .003$). The two-way ANOVA also yielded a significant main effect for the participant group with a small effect size, $F(2, 161) = 6.16, p = .003, \eta_p = .071$, such that the average ranking was significantly lower for clergy ($M = 6.23, SE = .207$) than for consumers ($M = 6.93, SE = .177, p = .032$) or clinicians ($M = 7.12, SE = .155, p = .002$). The mean difference between consumers and clinicians was not statistically significant. All pairwise comparisons are adjusted using the Bonferroni correction.

We conducted a one-way ANOVA model comparing satisfaction ratings across three groups of participants: consumers, clinicians and clergy. There was a significant difference in mean ratings for the Keynote Speech with a moderate effect size, $F(2, 54) = 4.28, p = .019, \eta^2 = .137$. Post-hoc comparisons using the Bonferroni correction show that consumers ($M = 7.47, SD = .61$) reported the keynote speaker to be more useful than clergy participants ($M = 6.64, SD = .93$) did. Rating differences between clinician ($M = 7.17, SD = .87$) and the other two groups were not significant, however.

We did not find a statistical difference in the ratings for the Panel Presentations, $F(2, 55) = 1.95, p = .152$, Roundtable Discussions, $F(2, 52) = 2.75, p = .073$, or the conference overall, $F(2, 47) = 2.4, p = .101$, between the three participant groups. The equal variance assumption was verified using Levene's test for equal variances. In all cases, the assumption holds with F statistics (p values) ranging from 0.591 (0.557) to 2.635 (0.081). We confirmed the results above by conducting a Kruskal-Wallis Test, which makes no assumption about the normal distribution of the errors— a requirement in ANOVA and not satisfied here. The results confirm our previous findings suggesting consumers ranked the keynote speaker higher than clergy participants ($H = 7.14, df = 2, p = .028$) did. Specifically, the mean rank for

consumers (34.76) was higher than the mean rank for clergy (20.29), and the difference is statistically significant ($U = 14.48, p = .023$). Differences in the feedback for the Panel Presentations, Roundtable Discussions, or the conference overall between the groups were not statistically significant.

Quantitative summary

The participants found the conference to be useful and validating significantly more than they reported making an action plan. There were no group differences in these evaluations. The participants found the Keynote Speech and Panel Presentations more useful than the Roundtable Discussions. The consumers and clinicians found the conference more useful than did the clergy.

Qualitative analysis

For each quantitative question there was a field for “Additional Comments.” Participants were also asked, “What do you need to move forward with greater collaboration?” and “What resources do you have that you can share for a future directory of collaboration resources?” In a qualitative review of the participants’ 122 written comments in response to the questions, four themes emerged, which described the utility of the conference (Strauss & Corbin, 1998): (1) academic content, (2) communication between persons of diverse backgrounds, (3) connections among participants, and (4) plans for future actions.

Academic content

Participants described the academic content of the Keynote Speech as setting the tone for the conference as well as a report on what work is being done in other parts of the country. This includes increased acceptance of religion and spirituality in mental health care (Fukuyama, Puig, Baggs, & Wolf, 2014). The comments affirmed the importance of the, “reduction of stigma along with increased education and acceptance,” described in the talk.

Communication between persons of diverse backgrounds

Although the room was filled with religious, professional, and personal differences, a unity of language was realized. The participants’ comments on the ability of people to communicate across these differences can be organized into three categories: (1) inclusion across diversity, (2) empathy through shared experience, and (3) examples of collaborative communication.

Inclusion across diversity. Several participants spoke of their pleasure at being part of these conversations. One participant was surprised, “That it even happened. It is rare in my experience that all three of those constituents gather around any common table.” Clergy were particularly descriptive in their approval of the inclusive diversity of the conference. One wrote, “The conference was a representation of the vision of pulling together the community to treat the entire person.”

Empathy through shared experience. For several participants, these life narratives strengthened their emotional connections to the material presented. Said one person, “First person experience transmits understanding in such a direct way. Once the trail has been paved by that feeling level, at least for me, then the clinical and academic knowledge has more of a place to land.” Because the panel’s information came from people who described the arc of their personal experiences, participants expressed reinforced optimism and hope. Said another participant, “the panel had lived mental health experiences and their stories were real with positive recovery outcomes.”

Examples of collaborative communication. In addition to acknowledging the breadth of the presenters’ discussions and how the conversations had helped them learn, several participants commented on how they felt that the conference’s material set a framework for how to proceed in their own work. One person described the bridge between theory and individual:

The specific examples of how to talk about spirituality were excellent. Additionally, I appreciated [the] description of the cycle of support and how the role of the clinician is a part of a bigger picture. That was helpful for me to hear and internalize. I also have a better idea of how the different roles of clergy, family and clinician can come together to provide support. (see [Figure 1](#))

The combination of different types of presentation worked in a complementary fashion, “After hearing the three different perspectives of clinician, clergy and consumer, I came away with concrete examples of how the collaboration of all parties is most beneficial to consumers.”

Connections among participants

Participants’ comments identified two subcategories of connections as integral parts of what they gained from the conference: (1) personal and (2) project directed.

Personal. Although there have been many efforts to find pathways of collaboration between clergy and clinicians and consumers across many decades, these efforts are still not a normative part of most models of care. Therefore, those who work toward these collaborations can feel isolated. One comment on the personal value of the conference was expressed by the sense of being part of a larger project, “Just having that many people in one room who cared about this topic as much as I do was extremely validating.” The importance of bringing together a diversity of stakeholders was summed up by the comment, “Connections. Information is secondary to connections.” These established connections were consistent with the lifespan theories discussed earlier.

Project directed. In addition to personal connections, some participants commented on how the conference helped them form connections useful to

future projects. One commented on how the conference was, “a good opportunity to network with others and facilitate dialogue among providers.” Overall the comments demonstrated the opportunities to improve the continuity of mental health care through informal connections formed outside of the planned actions of the event alone.

Plans for future actions

Although the Roundtable Discussions did not, in most cases, lead people to report that they developed an action plan, several comments in the survey pointed out what had been useful and what action people hoped would be initiated next. The qualitative review identified three themes that emerged from participants’ recommendations for future action: (1) enact information, (2) further discussion toward collaboration, and (3) publish and disseminate a directory.

Enact information. Clinician participants’ comments indicated that they were ready to enact the information gained at the conference. One acknowledged the need for an integrative plan, “I gained insight on the importance of spiritual implementation in one’s plan and securing the right support systems to foster recovery in the whole person.” Another person saw that this plan must, “address Consumers spirituality needs / concern / practices through the intake process and treatment planning” (Figure 1). The participants described their sense of having new useful knowledge, “I really appreciate specific examples of how to talk to consumers about their spiritual relationships and resources,” and techniques through, “Ways to assess spirituality issues without using religious language as Dr. Shapiro described” (Figure 2).

Clergy too saw opportunities for action. Said one, “Sharing ideas with other people stimulated good conversation and brought up ideas that I will use in the programs at church as well as an educator, and clinician.” One clergy person described asking the congregation’s Caring Committee to, “extend their outreach to persons who have mental health and addiction issues in their families.

Further discussion toward collaboration. There was lively feedback about how to continue the conversations across the different areas of expertise. Participants described feeling as if they were at the beginning of an expanding initiative. Said one, “I was pleased to be part of a community that is trying to make sense of how spirituality and recovery come together ... a potent presence in the recovery process.” Added another, “So this for me was wonderful to hear people working at various edges of the exploration ... that there is a growing community of people working in this way.”

Clergy commented that they too felt the conference gave them a better understanding of how to contribute to mental health care in their role as clergy, “The biggest step now is allowing other ministries to find that they have a voice

and can help.” Once clergy put their voice toward mental health care there would then be, “Much to come on theologies of mental health.” Said one person, “It was helpful to hear how clinicians view themselves and their comfort level in relation to spiritual issues.” Another concluded that there was need for more dialogue because, “It seems harder for clinicians to know how to reach out to clergy than the other way around.” A succinct and salient summary question was, “What do clergy want their role to be as it relates to mental health, what do clinicians want their role to be as it relates to faith?” An interesting finding revealed that there is a need for, “More information from clergy and clinicians to consumers to educate them to the fact that we don’t view each other as enemies, and that their wellbeing is most important to us.”

For the conference participants, it will be necessary to meet in, “an ongoing forum,” where people can, “explore opportunities and share ideas and best practices,” because, “Just letting clergy know that you are there is not as helpful as having places where we can meet and discuss the issue face to face.” The fundamental need for collaborative meetings was summed up with, “Presentations bring people together, networking keeps everything going.”

Publish and disseminate a directory. Along with a consensus of a need for ongoing interaction through face-to-face meetings, participants expressed great interest in having a written or an online directory of local spirituality and mental health resources. Clinicians requested, “a list of community spiritual organizations” with “point persons to refer clients to” to “address spiritual needs more intensely when meeting with consumers.” Clergy noted that they “mostly encounter poor or homeless people” and therefore they need a, “resource list for low cost counseling/diagnosis.”

Summary and recommendations for the program

Five years of initiatives by the MHCD led to the implementation of the “Lives Well Lived” conference. The conference was a rare event: consumers and clergy and clinicians gathered around a “common table” to discuss both opportunities for— and barriers to—collaboration. Participants reported that the conference was a well-woven experience that demonstrated the efficacy of recovery initiatives, led by consumers, to move the complementary roles of religion and mental health care from symptom reduction to recovery and thriving (Davidson, 2003; Milstein et al., 2010; SAMHSA, 2004; Sullivan, 1998). The conference was possible because of MHCD’s commitment of resources to fund the *Director of Faith and Spiritual Wellness* position (now the *Faith & Spiritual Inclusiveness Director*). The conference was the outcome of subsequent programming developed by the director, with time spent to develop relationships through community outreach to congregations, as well as inreach to MHCD clinicians and consumers.

As described at the beginning of this article, there are many organizations that promote and guide the inclusion of religion and spiritual resources in mental health care. This is the first initiative that we are aware of that brought together all three constituencies with shared representation and leadership, as well as conducted an empirical evaluation of the utility of the meeting. This initiative has the further advantage that MHCD already offers a multitude of integrated services, through which the recommendations from the data can be implemented and sustained. The quantitative and qualitative analyses led to four major findings:

Categories are fluid

The first finding is that separating clergy, clinicians, and consumers into distinct categories is misleading. Many persons' life experiences have led them to find themselves within all of these categories. There are clinicians trained as clergy; there are clergy trained as clinicians. There are clergy as well as clinicians who have experienced mental and emotional difficulties that led them to be consumers of mental health care. The ability of a person to accept and publicly describe these life experiences becomes an affirmation of our shared humanity (Bruner, 1990; Corrigan & Lundin, 2001; Erikson & Erikson, 1997; Milstein & Manierre, 2012), motivating some participants to more actively seek to be inclusive of religion and spirituality (Sells et al., 2006). This conference demonstrated that through education and dialogue people will expand their ideas of collaboration. A subsequent effort will be to help them expand their networks.

The utility of unity across diversity

The second finding is that though the participants represented diverse clinical and clerical and cultural traditions, as well as diverse personal spiritual paths, as well as diverse mental and emotional difficulties, there was common language found to describe the depth of difficulty of one's mental illness as well as the multiple pathways to assess and engage the roles of religion and spirituality in personal mental health recovery and the generativity gained through helping contribute to one's community (Corin, 1990; de St. Aubin et al., 2004; Milstein & Manierre, 2012; Milstein et al., 2010). The presenters also demonstrated that it is not a requirement for clinicians and consumers be coreligionists to provide effective care inclusive of spiritual and religious resources (Beutler, Machado, & Neufeldt, 1994; Milstein et al., 2008; Propst, Ostrom, Watkins, Dean, & Mashburn, 1992).

Obstacles remain

The third finding was the challenges that participants enumerated about when and how to proceed from knowledge to networking. One approach was mapped out by the prevention science stages of the COPE model described

by the keynote speaker (Figure 1) (Milstein et al., 2010). Some clinicians expressed plans to incorporate the religion and spirituality assessment tools that were discussed (Figure 2) (Anandarajah & Hight, 2001; Pargament, 2007; Puchalski, 2006). Clinicians were not clear on how to build dialogue with clergy. Clergy indicated that though they feel comfortable with psychological idioms based on a history of basic mental health education in many seminaries (Abbott, 1980; Gorsuch, 1988), it was hard to find colleagues among clinicians. There was an expressed need to improve clinicians' "theologies of mental health" vocabulary— so as to improve dialogue and also to demonstrate to consumers that, "we don't view each other as enemies." Consumers, through their emotionally rich narratives, voiced their profound difficulties in the face of mental illness. They also described and demonstrated hard-earned recovery, through a renewed belief in oneself, which in turn can lead to renewed connection to a spiritual community. Therefore, consumers benefit when their clergy and clinicians facilitate professional complementarity: acknowledge borders and build bridges (Figure 1).

Consumer to lead

The fourth finding is that the prime organizers of clinical and clergy resources will need to be the consumers themselves. Clinicians and clergy at the conference spoke repeatedly about how they were guided by consumers to expand how they think about mental health and religion. The persons best able to discern what from their religion could be seen as a resource—or a hindrance—to wellness would be the consumer. Therefore, the consumer does not wait. The consumer seeks to find a congregation that will provide a solid welcome and informs their clinicians of the importance of their spirituality (Davidson et al., 2009). This includes networking with peers to identify welcoming congregations (Salzer et al., 2010). The roles of clergy and clinicians will be to serve as care collaborators who encourage and are responsive to the assertive self-representation of consumers. Open communication builds a team to sustain recovery and a path back to wellness (Figure 1) (Milstein et al., 2010). It is recommended that the next efforts emphasize learning directly from consumers and working with consumers to develop the content of their dialogue with their clergy and clinicians.

Limitations

There were several limitations to our methodology. First this was a selected sample of persons who in some way had already expressed interest in religion and spirituality in the context of mental health. Next efforts will need to expand the breadth of persons participating to discuss the benefits and limitations of the inclusion of religion and spirituality in mental health care, and to

see if a more diverse sample would also be interested in implementing some of these ideas. A second limitation was that this was a cross-sectional sample from one metropolitan area. Longitudinal research will be necessary to determine if implementation of the suggestions from the conference will lead to improved mental health outcomes, in multiple settings.

Conclusion

The positive feedback of this sample supports future efforts toward community education. The conference participants requested two resources to facilitate communication. First, that there be continued meetings, because sustained education and networking would improve ongoing collaboration. Second, that a directory be distributed and available online for reaching out to develop individual collaborations. Plans have been made at the MHCD to run a program of dialogues with MHCD clinicians and peer counselors to assess how to proceed. MHCD has also now put a directory online (Mental Health Center of Denver, 2016).

In Denver, after 5 years of outreach, inreach, and program planning, 90 persons met to further their process of listening, networking, and learning to incorporate religious and spiritual resources into treatment, recovery, and mental wellness. The participants identified multiple religious and spiritual resources to facilitate mental health care. When we find common vocabulary, as did the conference participants, we can create narratives that will improve care through collaboration and cooperation between consumers, clergy and clinicians.

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