Clergy/Mental Health Staff Roundtable Pilot Project

USC Center for Religion and Civic Culture

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Introduction

Spirituality and religion in tandem with mental health care can be part of a healing process that treats the whole individual.

Individuals deal with various levels of trauma, including loss and bereavement, sickness and health, and mental illness—such as depression and schizophrenia—and even the chaos of everyday life and family disturbances. For many people in Los Angeles County, houses of worship are the first places they turn to for counseling, advice, support and a listening ear. While many clergy have accepted this role as part of their dedication to their faith and community, many lack the training, support, and infrastructure to provide effective services to people in need and to make appropriate referrals outside their congregational walls when necessary.

On the other hand, mental health providers and social workers within Los Angeles County do not always understand the nuances of particular communities where clients reside. Clinical staff have unique knowledge and training to assist those in the recovery process, but they can overlook—or lack access to—an additional toolkit that may speak to people diagnosed with mental illness: the spiritual language. Spirituality and religion in tandem with mental health care can be part of a healing process that treats the whole individual. Efforts to connect the mental health and clergy disciplines are needed. Such efforts can create the opportunity for mental health providers to gain greater access to communities in efforts to support consumers and family members of loved ones diagnosed with mental illness, while religious leaders can gain access to a network of mental health resources to support their work in this realm.

Based on the model of the successful Rabbi/Social Worker Roundtable created by Jewish Family Service of Los Angeles, the Los Angeles County Department of Mental Health (DMH) has established the Clergy/Mental Health Staff Roundtable Pilot Project. The Clergy/Mental Health Staff Roundtable is a pilot program of the DMH focused on enhancing relationships between these two groups in order to more adequately equip clergy in their pastoral counseling and consultation, while also exposing mental health staff (MH staff) to the role that spiritual resources can have in counseling. The pilot

project was created with the specific aim of incorporating spirituality into the recovery process of individuals diagnosed with mental illness. In order to do so effectively, one of the central goals of the project is to promote collaboration and mutual-learning partnerships between clergy and faith-based organizations and mental health professionals and the public mental health system.

In general, clergy and MH staff have worked independently to meet the needs of individuals and their families suffering with mental illness. The Roundtables were intended to be a first step toward building bridges between these two care-taking groups in order to improve treatment, expand the resource base, and better assist the communities served. While there were previous efforts to work with faith communities in the county's service provision areas, most notably the "faith-based mental health consortium" organized by SPA 6 District Chief Yolanda Whittington, DMH had not previously created a formal structure and process to foster and support these types of collaborations. Initially, DMH selected Service Planning Areas (SPA) 6 and 7 in which to pilot the project, with the hope that what was learned from this phase could be institutionalized across all county SPAs.

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The Center for Religion and Civic Culture (CRCC) at the University of Southern California provided consulting services to document the process and learnings of the Roundtable pilot, identifying the strengths and successes, as well as the areas that may not have succeeded as well, with the goal of improving the program and perhaps expand it. CRCC gathered information on the pilot program process through a series of in-person and telephone interviews with the program consultant, the Roundtable facilitators, clergy, and MH staff—including parent and peer advocates—who participated in the monthly Roundtables. Each Roundtable participant received an invitation to participate in these interview. A total of seventeen participants agreed to the interview process, nine from SPA 6 and eight from SPA 7.

Our objective for the interviews was to gather information in the following areas:

1. Participant background and professional training
2. Motivating factors for participation in the Roundtable
3. Perceived benefits of the Roundtable

4. Understanding how the group interacted with each other and whether rapport was generated through their interaction
5. Information about topics discussed
6. Ways in which collaboration and referrals are occurring as a result of the Roundtables, and finally
7. Any suggestions and feedback from participants about the overall Roundtable experience.

This report concludes with a list of possible strategies for enhancing the success, impact and effectiveness of the Roundtable program.[1]

[1] In order to maintain the anonymity of the Roundtable participants, we have adopted a style that does not include identifying those interviewed beyond their status as either MH staff or clergy.

Background and Training of Roundtable Participants

Familiarity of MH staff with Religion

Despite their lack of professional training in religion and spirituality, the MH staff that we interviewed recognized the significance of religion in the lives of the consumers they serve.

While mental health professionals tend to have lower levels of religiosity than the general population[2], the MH staff who participated in the Roundtables tended to be either currently or previously involved religiously. Some reported being highly involved in congregational life, even to the point of taking on leadership roles in their place of worship, and others had been raised in a religious tradition and now participated only occasionally, such as on holidays or special occasions. The religious traditions represented were Christian (including Catholic, Protestant, and Christian Science) and Jewish.

The Training of MH staff Regarding the Spiritual Realm

None of the MH staff had received formal training in their clinical degree programs regarding the role of religion and spirituality in the lives of consumers. Some MH staff reported that their training programs had taken a holistic approach to treatment—which meant not minimizing spirituality in the lives of clients—the programs did not include classes specifically geared towards learning how to address issues of religion or spirituality.

[2] See Koenig, H., "Religion and Mental Health: What Should Psychiatrists do?" *The Psychiatrist*, 32, 201–203 (2008), and Bergin, A. and Jensen, J., "Religiosity of Psychotherapists: A National Nurvey." *Psychotherapy*, 27, 3–7, (1990).

Despite their lack of formal training in religion and spirituality, the MH staff that we interviewed recognized the significance of religion in the lives of the consumers they serve. This was especially true for MH staff in SPA 6. Many found the Roundtable very helpful, and perhaps long overdue. One MH staff in SPA 6 said the following:

> [F]rom my clinical experience, most conversations in therapy with clients of Latino or African American heritage will involve some sort of component of spirituality, nine times out of ten. And at the same time, they're going to these clergy, the faith-based leaders in their community, telling them all of this same stuff, asking for assistance. Basically we're both working with the same individuals, so it's kind of like we're collaborating to assist the same people. It was kind of about time that we started looking at these things and sharing resources and giving each other tips about how we deal with certain things.

Despite their lack of formal training in religion and spirituality, the MH staff that we interviewed recognized the significance of religion in the lives of the consumers they serve.

Another SPA 6 MH staff said that the Roundtable had helped to fill the training gap regarding spiritual issues. "I work with older adults so spirituality is huge for them. Every time I have a question, anything I need to consult with them [clergy] on, I have done that," he said.

One mental health program head reported that the first time she had consulted with a clergyperson regarding a case happened as a result of the Roundtable. She described a case involving a deeply religious child who felt his mental illness was a punishment from God. Unsure of how to proceed, she called a Catholic priest whom she had met through the Roundtable. As she relates her experience,

> He gave me some Bible verses to give to the social worker to use with him and gave me some ideas of ways to present helpers to the child, things like, "God says many people can help us along the way, like a psychiatrist and the therapist."...I definitely would call up [clergy] again. Even personally, I was like, "I want to talk to you about the devil inside!"

The Training of Clergy Regarding the Psychological Realm

While the MH staff who participated in the Roundtable did not have formal training in the religious realm, clergy did have some formal training in psychology or in counseling. All of the clergy that were interviewed had either taken pastoral counseling classes as part of their seminary training or as a part of their continuing professional development. In fact, one clergyperson had extensive formal

training and experience in the mental health field, having earned a master's degree in psychology and worked as an MH staff before entering the ranks of the clergy. Other clergy also reported hands-on counseling experience. For example, one clergy member has done 40 hours of crisis counseling, and another had earned his certification as a chemical dependency counselor. A third clergy member completed a summer internship at an addiction recovery center for dual-diagnosed clients.

Because of the significant role that counseling plays in their work, our interviews identified a key finding: clergy would greatly benefit from additional training in understanding psychological processes. The clergy we interviewed reported spending anywhere from four to thirty hours per week counseling congregants, both formally and informally. The Roundtable has proven fruitful for them as they carry out this aspect of their ministry to individuals and families within their congregations. One pastor said that participating in the Roundtable has improved his ability to counsel congregants because it has "increased my arsenal of tools to work with." Another clergy member said that participating in the Roundtable was helpful in allowing him to know when he was moving outside of his scope of practice:

> One of the things we talked about was finding out whether or not something was beyond what you could do. That's helped me a lot, to say, "OK, I see what's going on, but this person needs something else." That's been the most direct outcome of this…I've been able to recognize this and perhaps point them in a direction where someone could give them help….

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Motivating Factors for Participating in the Roundtable

An MH staff person who directs a DMH contracted agency said that he felt that the people who agreed to participate in the Roundtable did so because they recognized their own limitations, as well as the benefits of collaboration.

Virtually every clergy and MH staff stated that they participated in the Roundtable because they wanted to 1) build supportive bridges between clergy and MH staff, 2) obtain knowledge and insight into the role that each professional plays in serving the community, 3) exchange information about available resources for consumers, and 4) expand their opportunities for collaborative consumer care.

Many MH staff sought practical strategies to assist client care. For example, one clinical psychologist who oversees a caseload of 300–400 consumers, joined the Roundtable because she wanted to gain insight from clergy on how best to deal with religiously-based resistance to treatment. She said,

> I work with chronic psychotic disorders primarily…and you get a lot of things like, "I don't need medication; God will save me," or "I don't need to come to you; I go to my church." So just trying to come up with a way of us working together to understand how we can say, "It's great that you have your faith and that you believe in God, but it's also OK to take your medicine."

An MH staff person who directs a DMH contracted agency said that he felt that the people who agreed to participate in the Roundtable did so because they recognized their own limitations, as well as the benefits of collaboration.

> People who joined this, it seems to me, came in with a similar intent. We know we have a community with unending needs to serve. We know that sometimes those needs exceed our training and perspective, and if we're going to be able to serve people in a culturally relevant way, it will need to include being able to help connect them to others that are going to meet different aspects of the need, whether it's spiritual needs or health needs.

The desire to learn was also a motivating factor for many. As one MH staff put it, "My main expectation was to learn from clergy and learn their point of view in terms of mental health…" This desire to learn from others was similar for this clergyperson:

> I saw it as an opportunity to increase my understanding of psychological issues and…to also share whatever insight I could share with those at the Roundtable about the Catholic Church's understanding of mental illness….

While overall, members participated because they wanted to increase their knowledge base, they also wanted to help educate others and thereby reduce stigma related to mental health issues. One MH staff related this desire this way:

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> In a lot of cases mental health has been stigmatized, and one of my aims is to help destigmatize and help educate people more about mental health, how one can work with it and how it's not only just the part of your physical health, but it's a part of your whole being.

Although most people attended the Roundtable with a very clear idea of what they hoped to gain, others didn't have a specific objective in mind. For example, when asked what he had hoped to gain by participating in the Roundtable, one clergy member replied, "I didn't know. I just knew that I needed to be there." Another clergyperson added that he didn't have a predetermined set of expectations for the Roundtable, rather, "I went in to see what it was all about."

Additional Motivating Factors

While the overwhelming majority of those we interviewed seemed to share the bridge-building vision of the Roundtable, some had at least initial motivations that evidenced different priorities. For example, one clergy person saw the Roundtable as an opportunity to share her religious views with an eye toward proselytizing. When asked what she was gaining from the Roundtable she said, "I'm so grateful for this opportunity to be in that Roundtable. I'm getting something that I've prayed for: an opportunity to bring [the religious perspective] that I've been given to any [setting]." While she came to the Roundtable to give her particular religious perspective to the group, she did not see it as a place where she was able to receive much in return. When she was asked if she had gained anything that

would help her in her work, she replied, "Not really. I have to be honest with you." It is important to note however, that regardless her motivating desire to bring her religious perspective to bear on the Roundtable, she never advanced any proselytizing activity during the Roundtable sessions. We do not know whether she pursued such activities outside of the Roundtable setting.

Another clergy member gave evidence of another type of motivation for participating in the Roundtables; he thought it would be a place in which he would receive the training necessary that would allow his congregation to be a grant funded service provider for DMH. However, when he saw that the forum was geared more towards conversation than compensation, he stopped attending. He related his reasoning:

> I don't think we ever got into the specifics of what I really wanted to deal with there. We talked about a lot of things, but we never really got into the specific training, which I brought up a couple of times, that I could not continue to meet on a regular basis talking about whatever. I needed training. That's the only thing I was interested in, the group providing training and funding.

Perceived Benefits of the Roundtable

Relationship Building

When asked whether participating in the Roundtable had aided them in their work as MH staff or clergy, all of those that were interviewed provided at least one example of how the Roundtable had proven beneficial to them. The most frequently mentioned benefit was having developed relationships with specific individuals that participants would feel comfortable calling upon for advice or assistance in their work. One clergy person said that she has "some of their [MH staff] numbers programmed into my phone. As things arise, I do have this web of resources and people I know by name that we can contact." Another clergyperson said he thinks that at its most basic level, the Roundtable was "beneficial in putting a face to the Department of Mental Health and being able to have perhaps someone to call."

Several MH staff stated that the Roundtable helped them feel more connected to individual clergy and to the communities in which their consumers reside. For example, one MH staff member related how much more he feels connected to the faith community in the area in which he works:

> I would hear the names of churches, but now I've actually developed relationships with some of the clergy at those churches. I know more about the programs those churches are offering. I mentioned the conversation with [clergyperson]. I actually went to his…parish. So yeah, definitely, I feel more connected, informed…I don't live in the community, but now I feel like I'm more connected, for sure.

Not only are MH staff making it a point to go to clergy, as in the example above, but clergy are also making it a point to come to MH staff. When they come, some come bringing those in need. For example, one clinical psychologist has developed such a strong relationship with one of the pastors who participated in the Roundtable,

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that now the pastor feels motivated to personally escort his congregants to the clinic where the clinical psychologist works:

> I've seen him [clergyperson] at least three times in here. He's walked people into the building. Clinic [X] can be an intimidating place. It looks like a fort. But he's walked people in through the front door up to the glass window and made sure that they get connected. That's powerful.

Increased Knowledge and Community Awareness

Many participants stated that the Roundtables offered opportunities to learn from others and facilitated the process of communicating across disciplines.

Many participants stated that the Roundtables offered opportunities to learn from others and facilitated the process of communicating across disciplines. "I think I've appreciated developing an understanding of the vocabulary that people use to define their experience," said one MH staff. Similarly, a clergyperson stated that as a result of attending the Roundtable, he has gained a new respect for and awareness of what MH staff do. He has shared his new insights with his staff so that they can "help to spread the good news that mental health is a means to healing as well." Both clergy and MH staff stated that they enjoyed having the opportunity to learn about other faith traditions and how those traditions perceive mental health and illness. Awareness about community resources, whether faith-based or DMH funded, was frequently mentioned as another benefit of the Roundtable.

Participating in the Roundtable has increased one social worker's knowledge and improved his credibility with clients. When he tells clients that he is part of a discussion group that includes clergy and MH staff, they become very interested that his approach is not anti-religion or anti-God, and thus helps to build rapport with the clients. This then gives him the opportunity to assure clients that the mental health approach "considers [religion/beliefs] an important part of your life," that they seek to build on, not to tear down.

Increased Self-Awareness

For some of the clergy, participating in the Roundtable had the unexpected benefit of making them aware of their own health and safety needs. Upon hearing another clergy member say that their tradition requires two weeks off, one clergyperson related his reaction:

> That tweaked my brain, because me and my wife, we've been hitting this thing hard for five years, and we've only taken

maybe five days in that five years. When I heard that, I started thinking, we need to really, really take some time off, for our well-being.

Another clergy member, who had been having significant problems with a congregant, realized that some behavior was simply unacceptable. She says that the Roundtable members helped her to "get over my flaw of being a pastor and thinking, 'It's just that person and they'll get better.' They helped me say, 'You have to confront what is not OK.' That was really helpful."

Increased Mutual Support

The Roundtables have not only enhanced the ability of MH staff and clergy to help consumers, but relationships they have formed have also opened the door to mutual support between clergy and MH staff in times of need. For example, one MH staff shared that after a DMH employee passed away, one of the clergy from the Roundtable went to the clinic where the DMH employee had worked and performed a ceremony to help employees in that office to think about their loss in a more spiritual manner.

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A Reduction in Feelings of Isolation

Clergy, more so than DMH, expressed their appreciation for having a forum to discuss job stressors, personal struggles, and difficult situations. More than one clergyperson expressed appreciation for the opportunity to have their experiences validated and normalized as they listened to others share similar stories. One explanation for why clergy may have benefited more in this regard may have to do with the fact the MH staff tend to have more opportunities to discuss situations through their time spent in supervision or case consultation. Conversely, clergy often work alone, or with a small team of ministers, and "case consultations" do not factor into a day's work. Thus, one of the more unexpected results of the Roundtable was to create a space where clergy could process their work issues with other clergy and with MH staff, thus reducing feelings of isolation or the experience of feeling overwhelmed in their everyday work responsibilities.

Roundtable Format and Discussion Topics

When asked what topics they most enjoyed, the participants consistently cited the "burning issues" discussion as their favorite part of the meetings.

Format

The typical format of the Roundtable meetings included three distinct elements: 1) Introduction of new people 2) Discussion of "burning issues" and 3) New topics. Within this basic structure, however, each Roundtable session was participant directed with the assistance initially of the consultant, and then of the facilitators. This resulted in one format difference between the two Roundtables. In the SPA 6 Roundtable, the participants, by their choice and consensus, decided to open and close each Roundtable session with prayer. This option never came up in the SPA 7 Roundtable. Thus, this group-determination of how each Roundtable session would be structured, how much time would be spent on each element, including the topics of discussion and even adding particular elements, goes a long way toward explaining why participants found that the Roundtables were both a positive and beneficial experience for them.

Favorite Topics

When asked what topics they most enjoyed, the participants consistently cited the "burning issues" discussion as their favorite part of the meetings. The "hot" or "burning issues" were described to us as "any concerns, any particular issues, anything on the news, a case or concern that any of the clergy or the DMH staff have," that would be brought up for discussion with the group. These burning issues were typically real-life dilemmas that clergy or MH staff were encountering in their daily service to the community, and through the group discussions, the participants were able to think through some of the questions or quandaries associated with these issues. These discussions were key components of the entire Roundtable process.

Missing Topics

When asked if they felt that there were any issues or topics that should have been addressed and were not, most participants responded in the negative. However, one MH staff expressed regret that legal-ethical issues such as state regulations regarding confidentiality and abuse reporting were not discussed, especially at the onset of the Roundtable. She explained that clergy get frustrated when they try to follow up on client referrals they have made to county contracted agencies only then realize the restrictions on providing information, or requirements for reporting that MH staff are required to follow by law.

In the other Roundtable, however, participants identified the topic as an important point of discussion. We were not privy to the internal discussions of the Roundtables, or how particular topics were chosen for discussion and others were not. The structure of the Roundtable is dependent on the members, which makes this issue a function of this particular Roundtable and their internal decisions, not the Roundtable structure as a whole.

Most clergy felt that their knowledge of DMH services and programs had increased, sometimes exponentially, as a result of the Roundtable.

While most clergy interviewed felt that their knowledge of DMH services and programs had increased, sometimes exponentially, as a result of the Roundtable, one clergyperson felt that more time should have been spent addressing what DMH has to offer the community. She explains,

> I could still use more information about the structure of the entire department. I don't fully understand what's really available out there. And in particular I could use more information about counseling resources that are available for my community.

For many Roundtable participants, the missing piece was not talk, but action, and creating a model for working across disciplines toward a common goal. As one clergyperson put it, "As far as issues or topics, I think we covered a lot of issues and topics. But for me, it's how do we get a working model?"

Group Participation and Processes

One repeatedly expressed sentiment was that there seemed to be a high level of mutual regard between the clergy and MH staff who participated in the Roundtable.

The Significance of Client Contact

Roundtable facilitators all expressed their understanding that a key aspect of their role was to encourage participation from all participants. Despite their efforts however, some group members perceived that clergy contributed more to the discussion than MH staff, especially as it related to presenting burning issues. One MH staff attributed this to two factors; first, there was a slightly larger clergy presence, and second she, as well as some of the other MH staff, were administrators and they therefore had little client contact. Regarding the difference in discussion participation, she said, "one possibility is that I'm an administrator, so I don't have particularly that much direct client contact. We just didn't have as much fodder for discussion."

Building Cohesiveness

One repeatedly expressed sentiment was that there seemed to be a high level of mutual regard between the clergy and MH staff who participated in the Roundtable. "I think what I have appreciated and enjoyed is that there does seem to be a high degree of regard and respect for one another," said one participant. While the Roundtable group may have become unified in their mutual regard, it took time to become unified in their purpose. According to one parent advocate, "it took a while for the whole group to engage and go in the right direction." An MH staff member describe her experience:

> The first few months, it took us a while to really get a sense of what our purpose was, and I think in the last few months is when we really have come together and are sharing a unified purpose. I guess if you follow group dynamics, we kind of had our own forming, storming, norming. So I guess what I'm saying in essence is, I think once a month for a year, we're probably about where we should be, taking the time to get to

know each other, to trust the process, to trust each other, to become familiar with each other. I think it was a process that takes time.

Points of Contention in the Roundtables

RESEARCH. Although everyone interviewed stated that the overall experience was positive, the fact that there was a documentation project on the Roundtable pilot project was an issue that caused concern. Some SPA 6 participants expressed concern that there would be a "research" component to the Roundtable, but this did not trouble participants in the SPA 7 Roundtable.

Although everyone interviewed stated that the overall experience was positive, the fact that there was a documentation project on the Roundtable pilot project was an issue that caused concern.

In our visit to the SPA 6 Roundtable, the participants did not understand the documentation project. They believed that they would be research subjects and that USC researchers were using the Roundtable as a laboratory to extract information about community issues and concerns, and then potentially misrepresent these issues to the public. This perspective also emerged in interviews in which some participants expressed discomfort with any research effort involving the Roundtable. Others stated that although they themselves were not stymied by it, they could see its impact on the group. For example, one mental health program head noted that the research piece made some participants defensive and perhaps drove them away:

> [W]hen they heard it was going to be a research project, the fences went up very quickly. And that's when it was kind of like, "…What do you mean, research? What's going to be said? Sometimes things have come out negatively that have impacted the community negatively, and we're concerned about that." So that particular church did not come back.

The group facilitator had the same perception:

> We noticed that there were a few clergy, who are no longer in our meetings, that were a little hesitant to participate. But more than anything they were concerned about the research part of it, concerned that having their opinions and information discussed was going to be misinterpreted at some point during the research study.

The general sentiment from SPA 6 participants was that the purposes and plans for the research component were not explicitly stated at the beginning of the Roundtable, making some people experience difficulty in trusting the entire Roundtable process.

As noted, however, this issue did not emerge in SPA 7. Thus, it is important to note key differences in participant recruiting and organizing methods for the Roundtables, as well as larger differences in their composition. The project consultant created a process to recruit and screen participants for the roundtable project as a whole. The consultant was able to follow the process in SPA 7, but was not able to in SPA 6. In SPA 6, clergy were recruited to participate without a screening process. This, combined with longstanding sensitivities among some communities of color over past research abuses—and the feeling that they are over-studied with no practical outcomes or improvements to their communities—led to the skepticism and distrust that was encountered in SPA 6.

Many clergy and MH staff expressed an appreciation for the religious diversity of the group because it gave them insight into other faith traditions

RELIGIOUS DIVERSITY. Many clergy and MH staff expressed an appreciation for the religious diversity of the group because it gave them insight into other faith traditions. In SPA 6, no conflicts with a basis of differences in belief were reported. However in SPA 7, a discussion about the origin of psychosis resulted in one Roundtable member stating the belief that psychosis had a demonic source, and was reluctant to accept that perhaps there might be another explanation. This difference with the group has persisted, although the participant has continued to attend the Roundtable, despite the sometimes contentious atmosphere it creates in the group. Interestingly, participants in SPA 6 did talk about how one might distinguish between demonic possession and schizophrenia, yet rather than being a contentious topic, many noted this as an engaging and rewarding conversation.

Collaboration

Existing Collaborations

While one of the goals of the Roundtable is to increase opportunities for collaboration between MH staff and clergy, it is important to note that a significant amount of collaboration was already taking place before the Roundtable pilot program began. For example one MH staff member, a regional program director, worked with two MFTs and an LCSW to create a peer/lay counseling program at his church: "We screened and trained and support a number of volunteer peer counselors in the community. We oversee and continue to support that particular project." One clergyperson started a new church in an independent living facility for mentally ill, yet stable adults. They held weekly Bible studies and worship service in the recreational area of the complex.

Collaborations also existed in the form of consultation with MH staff who were not necessarily at DMH. Nearly all of the clergy interviewed said that although they may not have consulted with someone from DMH, they did at times contact a clinician for consultations. The clinician contacted was usually a private practice therapist they knew, or had been referred to from a list, for example as might be obtained from a group such as Catholic Charities. Recognizing the significance of religion in the lives of his predominantly African American clientele, one MH staff said that he would consult with clergy to get their views on medication, treatment and mental illness, even before the Roundtable began.

Another form of collaboration involves providing space for spiritual resources at treatment centers. One MH staff related that at her agency, an empty office was converted into a meditation room so that consumers and staff could have a quiet place for reflection and prayer. At another DMH contracted agency, donors support an onsite chaplain. The chaplain is available as needed when staff need consultations. The MH staff person who was interviewed said that over the several years he's been at the agency that, "I wouldn't say it's something that been frequent for me, maybe four times over the years." However, in his private practice, he has made spiritual resources available to his clients upon request.

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Embracing the Idea of Collaboration

Although many of the clergy and MH staff had already engaged in some form of collaboration, for some this was a new idea. For example, this clergyperson explained how the Roundtable had influenced his thinking:

> [B]efore I might not think of going to mental health and looking for resources. Now I would be more aware of it and I would have no problem in calling them. "I would like you to come and do a workshop that deals with anger" or "What are some of the key things to look for in mental health that's getting out of hand.

Clergy and MH staff are embracing the idea of collaboration because they see that some of the help consumers need is beyond their own scope of practice.

Another clergy member's lack of knowledge about available resources had prevented him from making referrals. When asked if participating in the Roundtable had increased his likelihood of making referrals to MH staff, he said,

> Yes. I have phone numbers. I can refer people to an emergency line. I'm definitely open to that. I didn't before because I didn't know. Before the Roundtable, I didn't have any of the resources.

Thus, clergy and MH staff are embracing the idea of collaboration because they see that some of the help consumers need is beyond their own scope of practice. In those situations, teamwork between clergy and MH staff is seen as vital, as one clergyperson said,

> We know that when there's people that can't be delivered and they need help that's beyond our scope, we need to send them to the mental health clinics. Mental health clinics, when somebody's so drugged out they can't give them any more drugs, they need to send them to church. We're both on the same page, working, trying to help people in our community. I'm a voice to that.

Future Plans for Collaboration

Whether MH staff or clergy had engaged in some form of collaboration prior to their involvement in the Roundtable, they were eager to pursue more collaborations and that the Roundtable was extremely instrumental in providing opportunities for cooperative in-

volvement in community care. Toward that end, many of the Roundtable participants were already making and carrying out plans to collaborate with colleagues they had met through the Roundtable. Some of the plans mentioned include the following: 1) having a clinician onsite at a congregation at least once a week to counsel congregants, 2) inviting clergy to set up a booth at a mental health fair, 3) inviting a clinician to address a congregation about mental health issues, 4) offering parish space for workshops on parenting, marriage and drug addictions, and 5) having "health month" at congregations in which the topic of mental health and illness was addressed.

Thus, the Roundtable both built on participants' previous experiences with collaboration and referrals, and provided opportunities for new relationships to develop, laying important groundwork for continuing consultation and referrals between MH staff and clergy.

Participant Feedback

Hopes for Continuation, Expansion & Implementation

Many others not only expressed a desire for the Roundtable to continue, but to expand and actually carry out the vision of collaborative care.

As the interviews concluded, participants were asked if there was anything else from their experience in the Roundtable that they might want to add. Several Roundtable participants expressed gratitude for the program and commended DMH for making the effort. They saw the program as valuable and worth their time. As this MH staff said,

> We're willing to put aside a couple hours a month and say, "This is really worth it. There's something to be gained here." And that says a lot, because everyone there is overworked. I'm not the only one. Whether it's clergy or mental health, we all have a lot on our plate. We're all juggling a lot. We all want to see people feel better and live better lives. So for us, it's worth it to show up. And I hope it's something that continues. I hope that they don't end it after the one year.

Many others not only expressed a desire for the Roundtable to continue, but to expand and actually carry out the vision of collaborative care. One MH staff says that he hopes that they're able to "expand upon this and maybe implement a lot of the things that we've talked about, to put action behind some of the words and ideas that we've expressed." Similarly, a clergyperson is looking toward taking the next step toward putting all of their discussions into action. He says, "I hope in the future that they will continue to go to the next level and take it a step further and to actually implement a working manifestation of all their efforts and their information-gathering to put it into actual use."

Finally, this MH staff person would like to see the Roundtables expand both in number of Roundtables and the number of people participating. She says, "We've already unanimously decided we want to continue. We want to open it up, have more people participating."

Summary

Overall, the Roundtable Pilot Program appears to have reached its goal of encouraging clergy and MH staff to build bridges, foster dialogue, and engage in cooperative care. The Roundtables also had unexpected positive results, particularly for clergy coming to a better understanding of "self care" and reducing their feelings of isolation. All pilot programs, by their very nature, have areas that need adjusting. In the Roundtable Pilot Program the most significant problem was largely a result of a difference in methodology in recruiting clergy, and adequately communicating to them the full expectations and scope of the program. This, combined with existing—and longstanding—community feelings led to a certain level of distrust, and even exit, from the Roundtable in one SPA. Our hope is that this report can be a resource as the DMH moves to the next phase in their mission to meet the needs of individuals and their families navigating lives with mental health issues.

Overall, the Roundtable Pilot Program appears to have reached its goal of encouraging clergy and MH staff to build bridges, foster dialogue, and engage in cooperative care.

Recommendations

Based on the data obtained from the interviews, we provide the following recommendations to build on and increase the successes of the Roundtables:

1. *Seek broader representation of religious groups in future Roundtables.* Despite the fact that the Los Angeles region is the most religiously diverse area in U.S., only three religious groups were represented in the Roundtables: Protestant, Catholic and Jewish. This may mean that multiple Roundtables in each SPA need to be developed, based on the communities within the SPA that are represented by the participants.

2. *Expand the Roundtable model to multiple Roundtables in each SPA, and to additional SPAs if possible.* Related to recommendation #1, establishing Roundtables across a broader geographic area within each SPA would also expand religious and racial/ethnic representation. In other words, the Roundtables should "look" like the communities in which they are located.

3. *Increase participation in the Roundtable from MH staff with direct client contact.* Several MH staff were administrators who mentioned that the Roundtables would have benefitted from more MH staff with direct contact with clients.

4. *Commit to a specific methodology of interviewing and screening participants, emphasizing clear communication about the intent and goals of the Roundtables.* A commitment to such a methodology would decrease the likelihood of participants having different motives for participation than the stated goals of the Roundtables, and would also serve to increase the likelihood that all parts will be understood and anticipated when the Roundtable is underway.

5. *Continue to include "burning issues" discussions as a regular part of the Roundtables.* All Roundtable participants experienced this as an important part of the project and provided them with a

tangible benefit for attending. This also provides "ownership" over the topics and discussion of each Roundtable session for all participants, which in turn, should deepen their commitment to the Roundtable and to maintaining the relationships they have developed.

6. *Build on the initial successes of the Roundtables of providing mutual support, relationship building and opportunities to develop consultations and referrals, to developing models of collaborative care based on insights gleaned from Roundtable discussions.* Several participants, including both clergy and MH staff, noted their desire to put their discussions into action and start to develop these models of collaborative care.

7. *Build on the relationships developed between MH staff and clergy to utilize these relationships and the networks that clergy represent as ways for DMH to deliver educational material, resource information, etc. deeper into the communities it serves.* While it is important for individual clergy to be a part of the Roundtables, it is also important for DMH to think of clergy as representing community networks to which they may not currently have access. Thus, clergy and their network relationships with other faith and community leaders represent an opportunity for DMH to reach deeper into communities with mental health services, education, and the like.

8. *Related to recommendation #7, the Roundtables should make DMH materials routinely available to participants.* This will encourage clergy to become more informed about DMH programs and resources, and will also provide them with material they can distribute through their networks.

9. *Because the Roundtable program is oriented around religion and mental health issues, it would be important for the Roundtables to have at least one session early on in the process that was dedicated to members (whether clergy or MH staff) talking about the religious tradition to which they belong, including if they do not belong to any religious tradition.* This would allow all participants to express not only their understanding of their own tradition (or no religious tradition), but to learn from others about their tradition, highlighting commonalities as well as differences, boundaries, and points of convergence between their different traditions within the context of improving mental health offerings and resources.

Appendix: Evaluation Survey Instrument

As a part of the Clergy/Mental Health Staff Roundtable Pilot Project, the USC Center for Religion and Civic Culture (CRCC) constructed an evaluation survey that can be administered by organizers as one measure of the degree to which the Roundtable is achieving its goals. CRCC tested the survey with the two pilot Roundtables, although the total responses were quite low—less than five responses out of a total possible twenty-four responses. Yet even with this low response rate, the results were quite positive toward the Roundtables, and supported the findings from the interviews that participants had benefitted from the experience. Here we highlight a few responses from the majority of those who completed the survey, followed by the survey form.

The majority of the (very small) set of respondents said:

- The roundtable program served as a mutual learning forum between clergy and MH staff
- They have a broader network of clergy/MH staff to turn to for advice/support as a result of the Roundtable
- They have developed relationships through the Roundtable that have resulted in multiple consultations/referrals
- Felt that they were able to speak freely at Roundtable
- Would recommend the program to others
- It would be beneficial to expand the Roundtable program to other areas

DMH Clergy Roundtable Survey

This survey is meant to collect information about your experience in the DMH Roundtables. Feel free to take it anonymously if you choose. Please answer honestly. This information will be used to help improve the Roundtables and your opinion is important.

Name (optional):_____

Title (optional):_____

Organization (optional):_____

1. Please select:
- ☐ Clergy/religious lay leadership/FBO rep
- ☐ DMH Professional
- ☐ Parent/Peer Advocate

2. How many people do you serve in your position:
- ☐ 0 – 20
- ☐ 21 – 50
- ☐ 51 – 100
- ☐ 101 – 250
- ☐ Over 250

3. How many Roundtable sessions did you attend (total number attended):

_____

4. Before the program, how would you describe your understanding of pastoral counseling?
- ☐ Never heard of pastoral counseling
- ☐ Heard of pastor counseling before
- ☐ Have trained or used others trained in pastor counseling in my work with community members
- ☐ Proficient

5. Before the program, how would you rate your understanding of the Department of Mental Health?
- ☐ Little to no information about the DMH
- ☐ Heard of the DMH but did not use their services
- ☐ Work for or have recommended the DMH to community members
- ☐ Have had a close relationship with professionals and the DMH

6. Before the program, would you say that you feel connected to communities where your congregants/clients reside?

☐ Yes
☐ No
☐ Other: _____

7. Before the program, how would you rate your understanding of mental health resources available through the County Department of Mental Health?

☐ No understanding of resources available
☐ Little understanding of resources available
☐ Some understanding of resources available
☐ Recommend resources to community members
☐ Use resources regularly in professional work

8. Would you say you have gained what you hoped to gain from your participation in the program?

☐ Yes
☐ No

9. Please discuss your response to the above question:

_____
_____
_____

10. Did the roundtables result in your feeling more connected to clients, community, resources?

☐ Yes
☐ No
☐ Other

11. Would you say the roundtable program served as a mutual learning forum?

☐ Yes
☐ No
☐ Other:_____

12. Please discuss your response to the above question:

_____
_____
_____
_____

13. Would you say the roundtable program helped you gain trust in the work of your counterpart (clergy or DMH professionals)?

☐ Yes
☐ No
☐ Other:_____

14. How would you describe your relationship to clergy after your experience in the roundtables (check all that apply)?

☐ I have a broader network of clergy to turn to for advice and support
☐ I understand the work of clergy in relation to counseling in a more depth manner
☐ I consider clergy to be assets in the community when it comes to counseling
☐ I would recommend clergy members to clients in specific cases
☐ There has been no change in my relationship to clergy
☐ I am a member of the clergy
☐ Other: _____

15. How would you rate your relationship to DMH professionals after the program (check all that apply)?

☐ I have a broader network of DMH professionals to turn to for advice and support
☐ I understand the work of DMH better
☐ I consider DMH professionals to be allies when working with community members needing assistance
☐ I would recommend clients to DMH in specific cases
☐ I am a DMH professional
☐ Other: _____

16. Has the roundtable changed your thinking in regard to the relationship between clergy, mental health professionals and the Department of Mental Health? Please explain.

_____
_____
_____
_____

17. Would you say you have developed relationships through the roundtables that may be beneficial to your work?

☐ Yes
☐ No
☐ Other:_____

18. Please discuss your response to the above question:

_____

_____

_____

19. Have the relationships developed through the roundtables resulted in your involvement in mutual referrals or consultations with your counterparts (clergy or DMH) from the roundtables?

☐ Yes

☐ No

20. If you answered yes to the above question, how many referrals and/or consultations have you been involved in?

_____

_____

_____

21. If you answered yes to question 19, were these referrals and/or consultations successful from your view?

_____

_____

_____

22. Were you involved in referrals and/or consultations (with either clergy or mental health professionals) prior to your participation in the roundtables?

☐ Yes

☐ No

23. Did you find the structure of the roundtable program to be conducive to the aims of the program?

☐ Yes

☐ No

☐ Other: _____

24. How would you change the program, if at all?

_____

_____

_____

25. Did you feel you were able to talk freely and openly at the roundtable meetings?

☐ Yes

☐ No

26. Did you enjoy the presence of facilitators at the roundtable discussions?

☐ Yes
☐ No

27. How did facilitators impact the discussions during roundtable meetings? (Check all that apply.)

☐ Little presence felt
☐ Aided the flow of conversation
☐ Added pertinent information
☐ Allowed members to get to know one another
☐ Hindered the ability of members to talk openly

28. Would you recommend this program to others?

☐ Yes
☐ No

29. In your opinion, would it be beneficial to expand this program to other counties and cities?

☐ Yes
☐ No

Research and Writing Team

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About the USC Center for Religion and Civic Culture

The Center for Religion and Civic Culture at USC was founded in 1996 to create, translate, and disseminate scholarship on the civic role of religion in a globalizing world. CRCC engages scholars and builds communities in Los Angeles and around the globe. Its innovative partnerships link academics and the faith community to empower emerging leaders through programs like the USC Cecil Murray Center for Community Engagement and the American Muslim Civic Leadership Institute.

In 2002, CRCC was recognized as a Pew Center of Excellence, one of ten university-based research centers. Currently, the Center houses more than 20 research initiatives on topics such as Pentecostal and charismatic Christianity, faith-based non-governmental organizations, and the connection between spirituality and social transformation. The CRCC Interdisciplinary Research Group funds and organizes research on religions at USC. CRCC is also involved in the creation of scholarly resources, including the International Mission Photography Archive, the largest online repository of missionary photographs that document social change in non-Western cultures. The Center for Religion and Civic Culture is a research unit of the USC Dornsife College of Letters, Arts and Sciences.

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