STRENGTHENING THE
MENTAL HEALTH AND WELLBEING OF

Tomorrow's Faith Leaders in Theological Educational Settings

SAMHSA
Substance Abuse and Mental Health Services Administration

The Partnership Center
Center for Faith-based and Neighborhood Partnerships
U.S. Department of Health and Human Services

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Faith-based leaders are often the critical first point of contact for individuals struggling with their mental health. In times of crisis, many people of faith turn to these trusted leaders in their communities before they turn to mental health professionals.[1] Despite the important role of faith leaders within the continuum for mental health services, surprisingly little attention is given to helping faith leaders prepare for the mental health challenges and concerns they may face in the communities they serve.

It may come as no surprise that even less attention is paid to the mental health and wellbeing of the faith leaders themselves. A faith leader may be in the midst of their own wellness crisis and called upon to support others in crisis. Consequently, many faith leaders find themselves "leading while bleeding,[2]" which can only worsen their own mental distress and lead to burnout, compassion fatigue, and early attrition from faith leadership.

To address these challenges, on August 1, 2023, the Substance Abuse and Mental Health Services Administration (SAMHSA) partnered with the U.S. Department of Health and Human Services (HHS) Center for Faith-Based and Neighborhood Partnerships to convene an expert panel titled, ***Best Practices and Learning Collaborative for Theological Seminaries and Educational Institutions that Prepare Future Faith Leaders.*** The primary objectives of this panel were to:

Raise awareness of the mental health struggles faced by faith leaders

Identify innovative ways to increase faith leaders' skill and capacity to meet the mental health challenges of their future organizations where they serve

Empower the future generation of faith leaders in self-care and wellness

This report is based on the presentations and proceedings of the August 2023 event which described reasons for programs to address mental health as well as example initiatives. As a federal agency, SAMHSA and the HHS Center for Faith-based and Neighborhood Partnerships do not endorse or promote commercial or individual interests or services. Yet, certain examples of programs are identified in this brief because they serve the public good and are consistent with SAMHSA's mission.

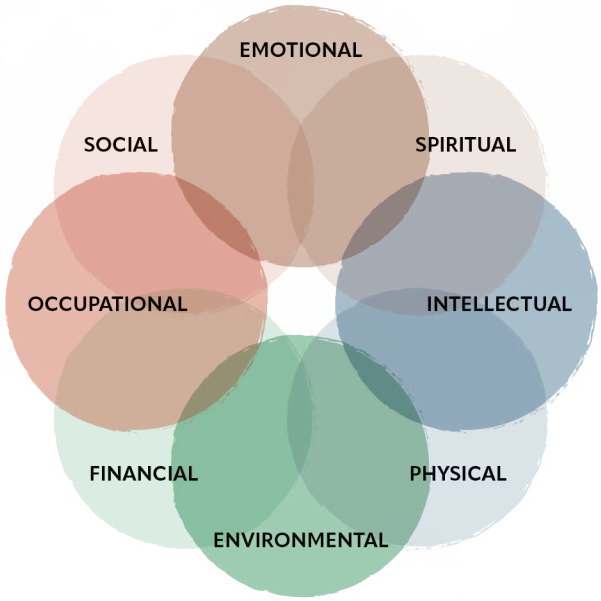
The Role of Faith Leaders in Addressing Mental Health in Communities

Faith leaders play an important role in identifying mental distress, connecting individuals with treatment services, comforting individuals experiencing mental health challenges as well as providing valuable ongoing support while individuals are on a journey to recovery. Eighteen percent of clergy report discussing mental health concerns with congregants at least once a month, and nearly three-fourths of all clergy report being approached at least once in the last year for help with mental illness.[3] One in four people of faith who need mental health treatment turn to their faith leaders for support in lieu of clinical support.[4,5] Additionally, faith leaders can fundamentally alter the way their congregants view mental health issues and professional mental health services,[6] which can also significantly affect whether individuals struggling with mental wellness go on to receive professional mental health care.

Sometimes, faith leaders are unaware of the local expertise and resources available to them. Further, faith leaders and the individuals they serve may be distrustful of the medical field which they may perceive as minimizing the importance of their being healthy in various dimensions of our lives, such as spirituality, to achieve longevity and improved quality of live. Many mental health programs and professionals rely on a strictly secular model for wellness sometimes summarized as the "bio-psycho-social." In doing so various other factors including spiritual wellness are treated as something "other" and are not considered in conjunction with these other areas of health and wellness.

Fortunately, alternative approaches are available. SAMHSA also published a model known as the "Wellness Approach."[7] This model includes eight areas of wellness that account for

Wellness Approach Model



CROSS-POLLINATION BETWEEN RELIGIOUS AND ACADEMIC COMMUNITIES

In order to help integrate mental health professions and the Jewish community in New York City, Yeshiva University has developed several programs to "cross-pollinate" between the religious and academic communities. First, faculty with the Ferkauf Graduate School of Psychology partnered with a local Rabbi group to offer mental health trainings to future Jewish faith leaders. Next, graduate students also participate in a mental health training clinic, where students work with a diverse group of 500-600 clients. Finally, students from the school of social work at Yeshiva University collaborate with faith leaders throughout the five boroughs of New York City. Students help religious organizations conduct strengths and needs assessments, build capacity, and design target resources.

all the factors that contribute to health. By including environmental, physical, financial, occupational, social, intellectual, emotional, and spiritual wellness into one holistic model, the Wellness Approach emphasizes the interconnectedness of well-being and health from across all domains of an individual's life.

The spiritual wellness dimension is a broad concept that represents one's personal beliefs and values and involves having meaning, purpose and a sense of balance and peace.[8] It includes recognizing the human search for meaning and purpose in human existence and developing an appreciation for life and the natural forces that existing in the universe, which may involve religious beliefs in faith traditions.[9] By utilizing a more holistic approach to health and wellness, professionals are better able to serve people of faith and spirituality in a way that is respectful to their beliefs. Incorporating a holistic view of wellness into their practice, mental health practitioners can help build trust between the religious and medical organizations. By doing so, faith leaders and mental health practitioners can build a respectful, symbiotic relationship where they are able to provide referrals and services to individuals in need. Additionally, this approach may reduce barriers and encourage treatment for faith leaders themselves.

Another approach that engages faith and communities as an element of wellness are called the Social Determinants of Health (SDOH). Healthy People 2030 defines Social Determinants of Health as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[10] As public health and health professionals, including mental health professionals, are encouraged to increase their use and consideration of SDOH factors[11], considering the conditions related to houses of worship and the leaders of these houses of worship can be another area of shared concern around which relationships and partnerships can be facilitated.

THE MUSLIM COMMUNITY SUICIDE RESPONSE MANUAL

Muslim Community Suicide Response — Maristan

According to a study published in JAMA Psychiatry, Muslim Americans are more than 2 times more likely to attempt suicide than Protestant Americans, and more likely to attempt suicide compared to Muslims living in Muslim-majority countries.

Despite being at particular risk, discussion of suicide within Islam is sometimes seen as taboo. To address suicide prevention among their community, Dr. Rania Awaad and her colleagues at Stanford University School of Medicine created the privately funded nonprofit, Maristan, and developed the Muslim Community Suicide Response Manual. The manual pulls together evidence-based practices for reducing suicide, and re-interprets them through an Islamic lens.

The manual includes verses from the Quran; integrates the science on suicide with the ethical and moral understanding of suicide within the Muslim faith; and articulates an Islamic mandate to intervene with those who are struggling. Further, Maristan developed sermons informed by evidence-based practices that Imams can take back to their communities. Imams acknowledge the value of this resource, noting that without the physical text in front of them it would be more difficult to effectively address suicide in their community.[1]

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1 Awaad R, El-Gabalawy O, Jackson-Shaheed E, et al. Suicide Attempts of Muslims Compared With Other Religious Groups in the US. JAMA Psychiatry. 2021;78(9):1041–1044. doi:10.1001/jamapsychiatry.2021.1813

Mental health professional associations, mental health systems, and their leaders can also consider supporting efforts that translate evidence-based treatments and tools through the lens of the faith and culture of diverse clients. Such efforts may be like those implemented in tribal behavioral health contexts known as "Two-Eyed Seeing." Two-Eyed Seeing is defined as "learning to see from one eye with the strengths of Indigenous ways of knowing, from the other eye with the strengths of Western ways of knowing, and to use both of eyes together."[12] In a similar way, the practices and wisdom of other faiths can be appreciated while also appreciating the best practices and evidence-based treatments embraced by mental health professions. Translating scientific knowledge into the languages of individuals practicing different faith traditions, while also integrating cultural perspectives and practices, can make mental health services more accessible to faith leaders, their members, and the community.

Finally, faith leaders, and programs for training faith leaders, can work towards increasing awareness and capacity of faith leaders to respond to mental health crises and challenges. Educational and training models range from increasing knowledge of mental health services to awareness of the signs and symptoms of mental disorders, including but not limited to programs like Mental Health First Aid and others included in the SAMHSA's "Expanding Implementation of Mental Health Awareness Training (MHAT) in the Workplace".[13]

Healthy Faith Leaders Make for Healthy Congregants

Studies show that many faith leaders enter their profession with high rates of mental health challenges. Nearly one third of religious leaders surveyed exhibited signs of post-traumatic stress disorder (PTSD)[14]; and over 30 percent of Christian, Jewish, and Muslim religious leaders reported symptoms commonly reported by individuals with PTSD.[15]

Holleman and colleagues report that faith leaders also experience more trauma experiences as compared to the general population. One way that researchers measure adverse past experiences is with the Adverse Childhood Experiences (ACEs) Survey. The ACEs Survey asks about eight types of traumatic experiences that people may have experienced before their 18th birthday. Studies suggest that when compared to the public, faith leaders enter their positions having experienced higher rates of household mental illness (36 percent vs. 25 percent); higher rates of emotional abuse (53 percent vs. 39 percent); and higher rates of sexual abuse (20 percent vs. 9 percent) as children.[16] These experiences put them at greater risk for future mental health and substance use conditions.

Further, nearly half of all faith leaders leave the profession within 5 years,[17] and nearly 65 percent of faith leaders are either on the verge of burnout or already burnt out.[18]

There are a variety of explanations for these challenges. First, many faith leaders experience the challenge of "boundary ambiguity" in their leadership role. It is not unusual for congregants to expect their leaders to be available around the clock to respond to crises or pastoral concerns. In addition, their social relationships are often connected to their place of work, which inhibits the creation of boundaries between their professional and personal lives.[19]

UNIQUE CHALLENGES FOR FAITH LEADERS IDENTIFIED DURING AUGUST 2023 MEETING

- Socially Isolating
- Emotionally and spiritually strenuous education and training
- Boundary ambiguity
- Expectations "sacrificing for the journey with God"
- Limited training on mental health, wellness, self-care
- Mental health stigma
- Financial Stress
- Limited training on recognizing mental health
- Limited resources to take to their congregations
- Political polarization of congregations
- Work-a-holic
- Secondary Trauma

Additionally, some faith traditions[20] and cultural communities[21] have increased levels of stigma related to mental health conditions and treatment. In fact, preliminary research suggests that clergy and clergy-in-training from marginalized and oppressed communities (e.g., racial and ethnic minoritized communities) may be at higher risk for stress and mental health conditions compared to others from non- marginalized communities.[22]

These findings are consistent with the forementioned Social Determinants of Health model in which social, non-health related environmental factors can have a significant impact on one's mental health and well-being. Thus, theological students entering seminary with a history of experiences related to housing insecurity, unemployment, and financial instability, or limited access to education or health care, may be more at risk for poor mental health.[23]

Although there has been research on the mental health crisis among faith leaders, there is significantly less research into how to address this challenge with the use of or development of evidence informed interventions tailored both for clergy in training as well as active faith leaders.

Challenges for Faith Leaders and Their Communities

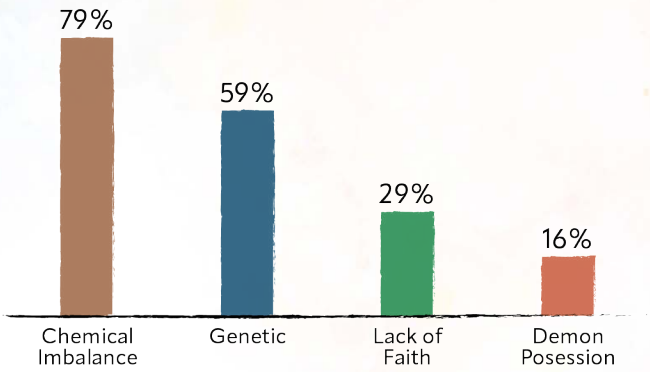
Whether from lack of familiarity, knowledge that can be received from training, or stigma of mental illnesses, it can be difficult for a faith leader to address individuals with mental illness in their congregations and communities.

STIGMA IN FAITH TRADITIONS AND CULTURE

Different faith traditions and communities may have different postures toward mental health. Surveys of religious leaders confirm that a vast majority of these leaders affirm a medical rationale for mental illness, and are open to helping their community connect with traditional mental health services.[24] At the same time, a minority of these leaders (10 percent) attribute religious or spiritual rationale for mental health conditions, with a large majority of this group identifying as part of the African American and evangelical Christian communities.[25] Leaders in these communities may be less open to addressing mental illness and exhibit higher levels of stigma about mental health challenges.

Research suggests that several communities experience high levels of mental health stigma. While not every faith, ethnic or cultural community is monolithic in its perspective, there are some themes that are common trends in specific communities. For example, some ethnic and cultural communities have different approaches to, beliefs about, and perceptions of mental health concerns. African American individuals describe high levels of negative beliefs about mental disorders, which has been defined as perceived stigma.[26] "'*What goes on in the house, stays in the house*,' is one of the most damaging statements we governed our families by… [it] has led to emotional and psychological trauma bottled up for years and has produced unwelcomed outcomes," said Rev. Dr. Que English, Director, HHS Partnership Center.

Beliefs Among Clergy Regarding the Cause of Mental Illnesses[1]*



*Survey respondents were able to choose multiple options; therefore, numbers do not sum to 100 percent.

[1] Holleman, Anna, and Mark Chaves. 2023. "US Religious Leaders' Views on the Etiology and Treatment of Depression." JAMA Psychiatry 80(3):270–273.

When navigating stigma, the context of faith-based and spiritual communities matter. It is helpful to recognize the stressors faith leaders experience when they arise from and serve communities facing daily pressures from racial and/or religious discrimination (including possibly being targets of violence) and/or the stressors of communities facing increased social determinants of health challenges. In these contexts, faith leaders navigate multiple layers of stigma to bridge access to mental health and wellness resources tailored to the unique experiences of individual faith communities. Faith leaders are aware reducing stigma requires resources grounded in the lived experiences of the communities they serve.

Asian American populations also report high levels of mental health stigma.[27] For these communities, as well as other religious and cultural communities where stigma toward mental illness is high, there is opportunity to address mental health conditions through the work of religious communities. Faith leaders in these communities can help normalize mental health challenges in the congregations, help mental health providers understand the unique faith and cultural barriers to mental health treatment, and support access to mental health services through referring congregants to faith and culturally sensitive providers.

Additionally, some faith-based or spiritual traditions have views of mental illness that can make discussing and addressing mental illness challenging. Muslim communities have historically had high levels of stigma related to mental disorders.[28] As noted by the American Psychiatric Association,

"Barriers stem from stigma about mental illness within the Muslim community itself, as well as from a health care system largely unprepared to provide linguistically and culturally appropriate care to people of the Muslim faith."[29] Experts share that stigma related to suicide and crisis care is "the stigma within the stigma of mental illness," making this issue especially hard to address in the Islamic tradition.

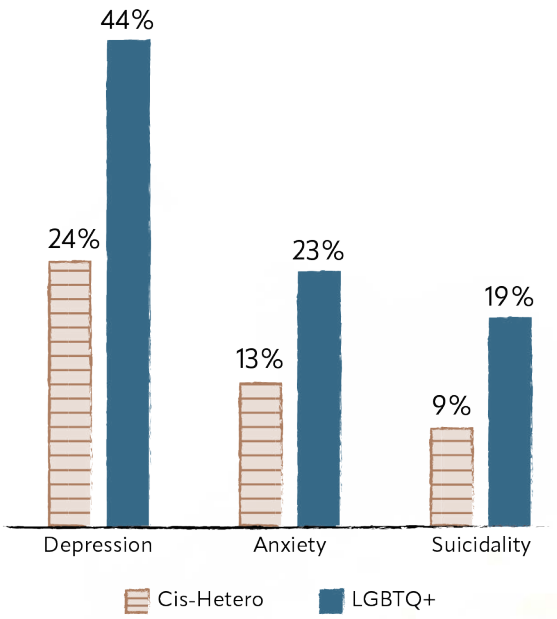
LACK OF RESEARCH ON DIVERSE RELIGIOUS TRADITIONS

Very little is known about the perception of mental illness and treatment among non-Christian faith traditions. It is imperative for more research to be conducted on these faith traditions. By understanding the ways other faith traditions view mental illnesses, scholars can identify gaps and needs regarding access to treatment for members of non-dominant faith traditions. Strategies that are successful for improving access in one religious community may be effective in other religious communities. For example, the Hindu religious traditions inherently connect spirituality with mindfulness, physical health, mental health, and emotional health. Hindu rituals and religious practices often involve well-being practices that encompass areas of wellness beyond spiritual wellness.

SEXUAL ORIENTATION AND GENDER IDENTITY

Preliminary, and not yet published, research by one presenter attending the meeting suggests that individuals who identify as LGBTQI+ (i.e., Lesbian, Gay, Bisexual, Transgender, Queer, and other minority sexual and gender identities) now comprise between 20-30 percent of individuals in Mainline Protestant affiliated seminary programs, though numbers vary by denomination and geographic location.[30,31] LGBTQI+ seminarians often face unique mental health concerns. First, they often enter their program with higher rates of mental health issues than their cis-gendered heterosexual peers. One study found that nearly 50 percent of LGBTQ+ seminary students reported clinically significant symptoms of depression, as compared to only 24 percent of their cis-gendered peers. Further, LGBTQ+ students often report a *decrease* in mental wellness while in seminary, a trend not seen in cis-gendered heterosexual seminarians. This suggests that there is something in seminary that is uniquely challenging to LGBTQ+ individuals.[32] Cumulatively, this suggests that LGBTQ+ students are at particular risk for mental health concerns during their theological education and may need additional support to maintain their mental health.

Percent of Seminary Students Reporting Mental Health Issues by Gender Identity[1]



[1] Holleman, Anna, and Bec Stargel. "Navigating Identity and Mental Health: A Study of LGBT Seminarians." Working Paper.

Self-Care and Overall Wellness

Subject matter experts at the August 2023 meeting emphasized that seminaries and other training institutions for faith leaders rarely teach about mental health, self-care, and overall wellness. They identified several reasons why seminaries may not take a more active role in the emotional education of future faith leaders.

Practical Models of Theological Training

There persists a tension between "classical/traditional" models of theological training and more "practical" models

Some may express resistance to integrating practical education components into theological education, including training on mental health and self-care

Limited Resources

Seminaries have limited resources to pay for mental health treatment, as well as broader efforts including mental wellness awareness and self-care classes

Prioritizing Other Institutional Concerns

Mental health isn't prioritized by the institutions, thus it is difficult to get buy-in from administrators within the programs

Although administrations and institutions often say that mental health, wellness, and self-care are important to their program, they are often the first classes either cut, made into electives, or put online to decrease costs

Seminarian Faculty

Seminary faculty are often ill-equipped to help students address their mental health issues

Seminary faculty themselves have not typically received training on mental health, wellness, or self-care

Seminary faculty may also be in the midst of the same mental health crisis as the students they teach

Mental Health Stigma

Although there has been significant work in reducing mental health stigma in faith communities, there continues to be fear and shame surrounding mental illness within certain traditions and communities

While faith leaders are educated about mental health concerns and are supportive of others, they often internalize shame about their own struggles

29 percent attribute mental illness to a lack of faith[33]

16 percent attribute mental illness to demon possession[34]

Featured Innovations from the Field

Despite the difficulties in addressing faith leader mental health, programs across the country have found ways to innovate and create solutions. This includes programs in academic and/or religious training programs that support leaders seeking to work in religious settings, including houses of worship. Although there are countless ways to address the wellness challenges for faith leaders, some of the most promising practices in these settings were discussed at the August meeting and are featured here.

TRUETT THEOLOGICAL SEMINARY'S COLLABORATIVE APPROACH TO INSTRUCTION ON SELF-CARE

Truett Theological Seminary believes that all seminary students should have a foundational understanding of self-care and mental wellness, but also of social issues they could expect to encounter once in their congregations (including domestic violence and substance use disorder). Because none of the faculty in the seminary had expertise in these areas, the school began cultivating outside relationships with other departments and with experts in the community. Theological students take a course where each topic is taught by a different expert from outside of the seminary. Further, seminary faculty also guest lecture in other departments to expose more students to theological education to encourage true cross-pollination.

APPRECIATING RELIGIOUS VIRTUES AND PRACTICES

Using data collected from the Seminary Formation Assessment Project, experts described how religious virtues and practices have both positive and negative effects on mental wellbeing. For instance, their study shows that higher levels of measured humility predict significantly lower levels of depression a year and a half later. Other virtues like forgiveness of others also predicted lower levels of depression a year and a half later.

In terms of practices, research on leaders being trained in the Christian tradition show that different types of prayer have both positive and negative effects on mental health. There are also psychological constructs, such as experiential avoidance (e.g., avoiding or distracting from distressing emotions), which have important impacts on mental health and spirituality.

Seminary students with greater levels of experiential avoidance had higher levels of depression. It is notable that these effects were seen even during the height of COVID-19 pandemic.[35]

Increasing attention to and development of these virtues, practices, and constructs in seminary settings may yield mental health improvements for individuals in seminary training.[36]

MAKING SPIRITUAL DEVELOPMENT HOLISTIC

Many seminaries have focused on the intellectual rather than the emotional growth of future faith leaders who will serve in houses of worship. Program models exist that acknowledge the interrelatedness of the health of the whole person and embrace the relational dynamics of spiritual formation. One such model is the Relational Spirituality Model, a pluralistic, holistic framework that provides specific ways to address mental health within spirituality. It focuses on the importance of relationships, both interpersonally as well as relationships with the sense of the divine.[37] Models like these provide specific frameworks that more deeply and specifically address the mental health of faith leaders themselves. Such models also provide opportunities to address mental health through the religious tradition's frameworks.

HEALTHY SEMINARIANS – HEALTHY CHURCH PROGRAM

Since 2014, Healthy Seminarians – Healthy Church (HSHC) has been advocating for a holistic approach to wellness for clergy and faith leaders. Through their research and advocacy work, HSHC help clergy, seminary communities, and church members develop their spirituality in conjunction with their emotional, mental, and physical development.

PACIFIC SCHOOL OF RELIGION'S CIRCLE OF CARE MODEL

Before the COVID-19 Pandemic, Pacific School of Religion (PSR) created a set of resources to ensure students were as supported as possible in a variety of ways. The Circles of Care model incorporates four distinct resource groups for students: (1) Campus Care Network, (2) Campus Pastors, (3) Director of Community Life, and (4) External Resource Persons and Organizations. The model was designed to engage all levels of the community in appropriate, boundary-specific levels of care and referral. "Referral up" to persons with increasing depth of pastoral and professional therapeutic experience was key to the effectiveness of the model. As PSR has shifted to a hybrid (online/in-person) model post-pandemic, their new initiatives have found ways to support the community in holistic care that have centralized traditional and new ways to create and sustain connection with students. Strategies include the Monday Online Café, where students can come together to discuss their wellness, wholeness, and struggles; and the Seeds of Dialogue, a memorial garden composed entirely of medicinal plants that was created in memory to a student who was killed by gun violence. Additionally, online trainings are offered as well as Mental Health First Aid to increase awareness of how to address mental health issues.

COLLABORATING WITH MULTIDISCIPLINARY PARTNERS

Some seminary-based faith leadership training programs foster collaboration between faith leaders and mental health and wellness organizations. Collaboration leads to shared resources and decreases the financial burden to seminaries. Collaboration also ensures that students receive evidence-based information about their mental health concerns and wellness more broadly. It also offers the opportunity for seminaries to "give back" to other organizations, and to spread their expertise on spiritual development to individuals who may not otherwise have access.

CENTER FOR CHURCH AND COMMUNITY IMPACT (C3I) HELPING SUPPORT COMMUNITY ENGAGEMENT AND WELLBEING

Viewing spiritual development at the community level, the Center for Church and Community Impact (C3i) at the School of Social Work at Baylor University considers religious organizations as one component of a community system. C3i helps churches understand their communities better, and how to better serve and engage them; they also help members in the community "who feel hurt, vulnerable, and marginalized" integrate into spiritual communities. C3i works in partnership with the Truett Seminary located within the Baylor University system. This partnership creates unique opportunities to address mental health and wellness within spiritual communities.

THE ASSOCIATION OF LEADERS IN LIFELONG LEARNING FOR MINISTRY (ALLLM) SUPPORTING HOLISTIC THEOLOGICAL EDUCATION

The Association of Leaders in Lifelong Learning for Ministry (ALLLM) recognizes the need for theological education to be holistic, but also ongoing. ALLLM also recognizes the importance of place, and of religious organizations within the broader communities in which they find themselves. ALLLM offers webinars about trends and changes in theological education, and clergy self-care.

In 2020, ALLLM engaged in a research project to determine the educational wants and needs of clergy. Continuing education provides an opportunity to address specific needs as they are identified by leaders working in houses of worship, which can include mental health challenges.

Seminary programs may support their alumni by offering continuing education training opportunities that address and strengthen mental health, for themselves and their congregants. This can happen as more religious leaders are seeing challenges related to mental health increasing in their communities.

CREATING OPPORTUNITIES FOR SOCIAL INTERACTION

One of the primary lessons of the pandemic was the absolute vital importance of social interaction. This has proven to be particularly salient for faith leaders, who often list social isolation, loneliness, and a lack of social support as some of the unique challenges of faith leadership.

CHRYSALIS FORMATION PROGRAM STUDY BRINGING FAITH LEADERS THROUGH ZOOM

One study found that bringing chaplains together through Zoom during the isolation period of the pandemic had significant results for faith leaders' wellness. Faith leaders who participated in the groups had significantly higher resilience and flourishing, and significantly lower burnout and spiritual struggles as compared to before joining the group. The Chrysalis Formation Program Study at the Danielson Institution at Boston University, an 8-week formation program for clergy, chaplains, and therapists and led by the Danielson clinicians, was formed from this work.

Looking Ahead

Improving faith leader mental health and wellness, and teaching self-care, are vital to the health and wellness of places of worship, congregations, and the broader community. Subject matter experts at the August 2023 meeting were asked to consider the future of faith leadership and faith leader education. The experts presented the following ideas for what is needed to move the field forward. They agreed that efforts to address faith leaders' mental health need be broader and include more diverse religious traditions; collaboration, at various levels, is going to be pivotal in making progress; and programming and research need to be multi-disciplinary, holistic, and cross-pollinating.

IDENTIFY NEW MODELS FOR TEACHING MENTAL HEALTH, WELLNESS, AND SELF-CARE FOR FAITH LEADERS

1. Compare curriculums of organizations that teach future faith leaders self-care and to address mental health. Look for commonalities to establish core components that can be applied broadly.
2. Look to Indigenous traditions and/or cultures, and to non-Christian religious traditions broadly, to broaden perspectives on types of wellness education for faith leaders. Explore how they incorporate self-care and mental health into their traditions and practices.
3. Ensure that models are adaptable to different religious organizations, as well as to the specific congregation and community contexts.
4. Collaborate. Bring together public health experts/researchers, seminary faculty, mental health clinicians, and frontline faith leaders from various religious practices to identify both successful programming and gaps in education.

RESEARCH THAT CAN IMPROVE FAITH LEADER WELLNESS AND MENTAL HEALTH

1. Research the current wellness and mental health of the seminary faculty. Also research the stigma around mental health and wellness that may exist among seminary faculty. Identify ways that faculty incorporate mental health, self-care, and wellness into their curriculum.
2. Identify resources that exist and gaps that need to be filled. Map the networks within seminary schools, but also between their department and other departments, and between their seminary and the community more broadly.
3. Identify which training and educational programs appear to work best in mitigating long-term burnout, compassion fatigue, and early attrition. Research the types of mental health, wellness, and self-care training faith leaders received in training and follow them over time.

CHANGE EDUCATION TO INCLUDE MENTAL HEALTH AND WELLNESS OF FAITH LEADERS

1. Incentivize faculty to work towards reimagining the curriculum in their own schools, since they have ultimate discretion on what is and is not taught.

2. Encourage governing bodies to embed new standards related to mental health, self-care and wellness into curriculum requirements, and to release example curriculum for mental health, wellness, and self-care programming.

3. Collaborate with outside organizations to cross-pollinate. For example, ask faculty from psychology or social welfare programs to come and teach about wellness and self-care. In return, consider where lessons about spirituality, such as religious education, may be appropriate in these cross-disciplinary environments.

IDENTIFY INDICATORS OF WELLNESS AND RESILIENCE FOR FAITH LEADERS

1. Have faith leaders identify and track their self-care habits over time. What seems to work best? Are there ways to encourage these behaviors?

2. Measure the number of quality relationships, both within their congregations or house of worship as well as outside of their vocational areas.

3. Encourage religious governing bodies, leadership, and congregants to consider faith leader mental health, wellness, and self-care; "seeing" faith leaders as humans who benefit by practicing self-care and wellness first just like their congregants.

Featured Resources

SAMHSA Faith-Based and Community Engagement: **https://www.samhsa.gov/faith-based-community-engagement**

SAMHSA Evidence-Based Practices Resource Center: **Resource Center | SAMHSA**

U.S. Department of Health and Human Services Center for Faith-based and Neighborhood Partnerships (Partnership Center): **The Center for Faith-based and Neighborhood Partnerships | HHS.gov**

HHS Partnership Toolkit for Youth Mental Health in Faith Communities: **Youth Mental Health and Well-being in Faith and Community Settings: Practicing Connectedness - PDF**

HHS Partnership Toolkit to Prevent Overdose and Support Recovery in Faith Communities: **Practical Toolkit for Preventing Overdose and Supporting Recovery in Community Settings - PDF**

HHS Partnership Guide for Faith Communities Serving People Experiencing Mental Illness: Compassion in Action: **A Guide for Faith Communities Serving People Experiencing Mental Illness and Their Caregivers - PDF**

Meeting Attendees

Dr. Chris Adams, Mental Health and the Church Initiative, Rosemead School of Psychology Biola University

Rabbi David Adelson, Hebrew Union College-Jewish Institute of Religion

Rawle Andrews, Jr., Esq., American Psychiatric Association Foundation

Shaykha Dr. Rania Awaad, Stanford University, Muslim Mental Health and Islamic Psychology Lab and Maristan

Dr. C Allison Baez, National American Indian Alaska Native Prevention Technology Transfer Center- Native Center for Behavioral Health

Rev. Dr. Lisa Banks-Williams, Wesley Theological Seminary

Helen Blier, Ph.D., Association of Leaders for Lifelong Learning in Ministry

Michael Cartledge, Ph.D., Princeton Theological Seminary

Rev. Cameron Cunningham, African American Behavioral Health Center of Excellence

Rabbi Andrew Goodman, Hebrew Union College-Jewish Institute of Religion

Dr. Coralanne Griffith-Hunte, Created for Greatness Leadership Group

Ellen Harwell, National Action Alliance for Suicide Prevention

Erin Hill, The Center for Church and Community Impact, Garland School of Social Work, Baylor University

Anna Holleman, Duke University Clergy Health Initiative

Matt Hufman, In Trust Center for Theological Schools

Rev. Ann Jefferson, Pacific School of Religion

Dr. Gihane Jeremie-Brink, New Brunswick Theological Seminary

Kimberly Moore, Yeshiva University

Amy Porfiri, American Psychiatric Association Foundation

Dr. Angela Reed, George W. Truett Theological Seminary, Baylor University

Rev. Abigail Rusert, Princeton Theological Seminary

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Dr. Steven Sandage, Boston University

Rev. Katie Strednak Singer, Immanuel Presbyterian Church

Sajani Sukhadia, Arsha Vidya Pitham - Institute of Vedanta, Sanskrit, Meditation and Yoga

Dr. Ila Sukhadia, Arsha Vidya Gurukulam

Rev. Dr. Beth Toler, Moravian Theological Seminary/Moravian University

Dr. Harold Trulear, Howard University School of Divinity

Dawn Tyus, PhD, LPC, Southeast Addiction Technology Transfer Center & African American Behavioral Health Center of Excellence

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