

CREATING COMPASSIONATE COMMUNITY

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ABSTRACT

The Mental Health Chaplaincy began in 1987, as a response to an increasingly visible number of homeless, mentally ill individuals on the streets of downtown Seattle, Washington, a city of almost 500,000 inhabitants. The chaplain walks a daily route through the city center and nearby neighborhoods, doing outreach and engagement with homeless, mentally ill individuals who have lost contact with care or who have no services. Outreach and engagement includes the four stages of approach, companionship, partnership, and mutuality. The aim is to share the journey from the street to stability within the community assisting individuals to find and use a variety of healing resources, and to foster the capacity for welcome and hospitality in the community, and to establish long-term, neighborhood scale patterns of care. The Chaplaincy works with clusters of local congregations, assisting in equipping churches to become centers of support with those who have experienced major mental illness. A healthy neighborhood includes those who are most vulnerable, stigmatized, and liable to be on the margin. Neighbors will be willing to share in the healing journey with a gift of themselves and their experiences, wisdom, hope, and faithfulness. To address the systemic causes of

hopelessness, and maximize the healing capacity of neighborhoods, the Chaplaincy has also been involved in a wider process of community education and organization around the needs and issues faced by those of us who struggle with mental illness. The Chaplaincy has been criticized as utopian but takes heart from the example of Geel, Belgium, with a 700 year history of neighborhood care for the mentally ill.

For the last ten years the Mental Health Chaplaincy has worked at creating neighborhoods able to care for those who experience acute and chronic mental illness. A special concern has been for those who are homeless, the person who is most vulnerable and isolated. The Chaplaincy reaches out to build community with individuals who are on the furthest margins of society. They are people who often are estranged from family and outcast from their own communities and culture, persons who are living outside the system of social services.

The 43-year-old man was sitting in the park. Rain was pouring down. He was soaking wet, having spent the night without shelter. He said nothing when greeted, simply staring at the ground, immobile. It took half an hour to establish contact, to connect with this deeply depressed individual. We simply sat in silence. My brief overtures elicited no conversation, only the barest of nods after a while. And then finally, slowly he agreed to walk with me to a nearby drop-in center. A few blocks took more than an hour. Over a cup of coffee he shared a little of his story. He had been in

the Navy, then administered a large office. He reported that he became "sad," started drinking and lost his job. He went on public assistance, received alcohol treatment, and stopped drinking. The sadness returned. He simply laid in his bed, stopped eating, and didn't collect his mail. He missed his appointments with the public assistance office. His support was terminated. He was evicted and began months of wandering the streets, sleeping in doorways. At the center he was welcomed and introduced to a companion who helped advocate with him for shelter, appropriate care, housing, and a place again in the community.

This paper begins with a statement and analysis of the problem of estrangement and hopelessness among persons who experience major mental illness. A vision of a humane and inclusive community is offered. The fabric of support created to implement this vision is described as a weaving together of outreach and engagement services with an effort to establish long-term, neighborhood scale patterns of care. The paper concludes with a brief retelling of the 700 year history of Geel, and the development there of a community deeply supportive of folk who face the long journey with mental illness.

STATEMENT AND ANALYSIS OF PROBLEM

In 1963 Congress passed the Community Mental Health Centers Act. This marked a major shift in the way individuals with mental illness were treated in the United States. Large state hospitals were to be replaced by a network of community based mental health centers.

Prior to 1963, the predominant mode of care for individuals with acute and chronic mental illness was institutionalization in a state mental hospital. In Washington state, in 1963, there were more than 6,000 individuals in three state hospitals, each located in rural areas far from major centers of population. The average length of stay was 25 years. Individuals with serious mental illness spent most of their adult lives out of sight and away from family and community. There would now be 11,000 patients in the state hospital system in Washington had the state continued to institutionalize seriously mentally ill individuals in this same manner. There are however, 1600 individuals in the state hospitals, with an average length of stay of six months. The vast majority of people who experience acute and chronic mental illness are in the community.

Across the country less than one-fourth of the expected community mental health centers were built and placed into service. The network of community-based care envisioned in the 1963 Community Mental Health Centers Act has never been adequately implemented. The King County mental health regional service network has a capacity to serve approximately 8,000 clients in long term care.

There is an acknowledged requirement for more than 1,300 beds in various kinds of residences to meet the housing needs of chronically mentally ill individuals, eligible for long term care services from the county. The Downtown Emergency Service Center alone reported an unduplicated yearly total of more than 1,000 homeless, mentally ill individuals seen in its facility.

Homelessness among persons with mental illness is a function of both the lack of adequate care and housing, and of the nature of brain illnesses. Brain disorders affect the very organ with which we process and organize our lives, severely altering or impairing the capacity to feel, think, act and relate. Affective disorders may plunge an individual into prolonged periods of hopelessness and despair, or produce extended states of mania. Thought disorders may include confusion and disorientation to time and place, hallucinations, or delusions. Changes in brain chemistry or anomalies in brain structure result in extraordinary experiences and behavior which can be profoundly disturbing to the individual, family and community.

The woman lived on the streets. She felt deeply unworthy and guilty. Her suffering was a punishment for which there was no possible forgiveness or healing. Only in a state of utter exhaustion and near physical collapse was she able to accept help.

The young man was sleepless for days. He marched constantly around the block, occasionally shouting to residents to get back

indoors. His duty was to protect the neighborhood from invasion.

His mission was authorized by no less than the Presiden, and God.

He felt himself invincible, with special powers to fight off evil.

The man heard voices. They directed his steps, told him what he could eat, where he should sleep, what he must look for each day to collect for his future. The voices told him whom he could trust and whether he should talk.

The illness experience may have led individuals out of connection and care and into the street. The community and the world of service and resources may be effectively lost to the mind once a person becomes homeless. Even when an individual maintains some degree of touch with reality, the programs have decepring registration and admission requirements. Transitional and long-term care services have a variety of interview and application steps to be negotiated. The move from the street to stability for a mentally ill person will necessitate working with a minimum of four agencies and seven or more agency staff, if the person continues to meet criteria for services each step of the way.

Management of the public mental health system has been contracted to a private insurance company. Admission to long-term care services and residential resources have been effectively restricted to individuals entitled to Medicaid - a federally-funded health insurance. Geographic focus and responsibilities were

eliminated, making ties between mental health centers and neighborhoods more tenuous than ever before.

The healing journey can be inherently difficult to begin with, fraught with barriers along the way, and frustrated by a lack of appropriate resources. Downtown Seattle has the most resources available in the region for homeless, mentally ill individuals. Even here shelters, drop-in centers, health services and meal programs are found only on the north and south periphery of the business, hotel, financial and government core. Survival services and mental health resources appropriate to the homeless and the most fragile of mentally ill persons are significantly sparse in the residential neighborhoods immediately around the downtown core, and are almost non-existent in suburban and rural communities.

A group of church-based programs working on the issues of homelessness in the Seattle area concluded, after a three year consultation and cooperative effort, that these patterns were not accidental. Homelessness reflects the way communities are organized with respect to who is welcome, the kind of services which are provided, and what housing is available. The ideal community was comprised of single family homes with public amenities such as libraries, parks and schools, and shopping areas confined to the provision of residential needs. Closer to the city center and business zones, communities included multifamily housing and social services perceived to be benign in their impact; for example, programs providing care to the elderly. Special needs housing and services for

the least popular of populations were generally relegated to poorer, transitional areas cut off from the mainstream of community life.

This is especially true for the most seriously mentally ill individuals in our midst. Few, if any, neighborhoods have intentionally organized their community to provide an adequate and appropriate continuum of services for those most fragile and vulnerable in their mental illness. Outreach workers, shelter providers, drop-in centers, housing programs and mental health services seeking to provide care for the most seriously ill and hard to reach individuals with mental illness must work exceptionally hard to secure entree, base and support, neighborhood by neighborhood. To organize communities with a priority on hospitality and support for those with brain illnesses is to introduce a fundamental change in focus, not only in the treatment and care of neurobiological disorders, but in the way we conceive and order common life.

A VISION OF CARING AND COMPASSIONATE COMMUNITY

The church-based homelessness working group developed a vision of neighborhood to serve as a guide for the work of the constituent congregations and programs. The key notion was that a healthy neighborhood recognized and included those who are most vulnerable, stigmatized, and liable to be on the margin or edge. The organization of a healthy neighborhood makes intentional and proactive provision for the stranger, the frail, the wounded, and the wandering. Just as hospitality was a premium in the waterless desert, so compassion is a primary virtue in the complexity of contemporary urban life. The

more highly organized and demanding our social and economic life, the more intentional and active we must be in providing welcome for and community with those who are isolated, left out, and left behind.

At the heart of the vision of compassionate community is refuge and sanctuary. Each neighborhood is called to have a place where one can rest and find aid 24 hours a day. An inn or two where the runaway child, the distraught and abused mother, the confused and suffering soul may be encouraged to come and begin healing. Such a refuge should have ready access to acute care, and be able to refer people to neighborhood emergency shelter and other survival resources. Out in the community, and at the door, should be folk who have the calling and skill to be present and listen, to build trust, discern needs, and bear the pain and struggle with another.

As quickly as possible people should have the benefit of participation in the life of a healing community, as a guest or novice in the process of moving toward a permanent, stable and meaningful residency. The neighborhood should be prepared to minister in the period of recovery and convalescence, as an individual and family repairs, as treatment proceeds, as new awareness and understanding is developed, and new skills and life practices are learned. These transitional services may be linked to more central, area wide or regional levels of resource, but they will be characterized at the community level of the steadfast involvement of neighbors willing to share in the healing journey with the gift of themselves and their own experiences, wisdom, hope, and faithfulness.

Provision should be made for appropriate housing and for place in the economic and social circle of the neighborhood for those who live with a long term, chronic or degenerative impairment. Homelessness ends not simply with a roof over one's head, but with a place where one is known, where there is supportive intimacy with a small group of others, where one can always return; a place where those who live nearby know and care about his or her well being, a setting where one gives, as well as receives.

A middle aged man suffers from a rare neurobiological disorder which results in symptoms of both major depression and schizophrenia. He was homeless for a period of two years in an uptown neighborhood. His church was the one constant point of contact. Staff and parishioners were puzzled and concerned about the man's behavior, his sitting long hours in the sanctuary and late night wanderings in the church yard. In consultations with the Chaplaincy, a plan of care was developed. One of the pastoral staff was assigned as the primary contact with the individual to build trust and provide consistent communication. A lay person from the church served as an informal companion by being available simply to listen and be present. The Chaplain served as a third member of the healing team, assisting with referrals to a mental health worker, shelter, the public assistance office, and eventually transitional and long-term residence. Even with

medication, and a permanent residence, the individual continued to experience occasional episodes of illness when he left the apartment for the street. The healing team has been able to act swiftly to assist in these crises, and is now at a point, where, with the help of the doctor and caseworker, early signs of illness onset are recognized and treated, greatly enhancing this person's stability. A key factor in this five year process has been the inclusion of the individual in the life of the congregation. While unable to hold employment, the man volunteers regularly in a variety of ministries and is recognized as an active member of the parish.

COMPANIONSHIP IS AT THE HEART OF WORK

The Chaplaincy's work of weaving a supportive fabric of care, neighborhood by neighborhood, began with two efforts. The chaplain developed and modeled a neighborhood service of outreach and engagement with homeless, mentally ill individuals. At the same time the Chaplaincy began training laity from local congregations in these neighborhoods to serve as companions of mentally ill individuals either in their church or in a community setting.

Outreach and engagement is a process which includes four stages: approach, companionship, partnership, and mutuality. During the approach phase the outreach worker begins by observing from a distance, noting how a person responds to others, how able they are to tolerate interactions and conversation,

and what needs the individual might have. The approach phase continues with brief attempts to develop a connection, to say hello, to come gently alongside the person. As the person is able and willing, the outreach worker introduces himself or herself, as a neighbor, as one who has interest and concern for another and their welfare.

As a relationship is acknowledged, the approach phase of outreach and engagement transitions into companionship, and the individual accepts the presence of another. In companionship, the interest is in sharing the journey, listening, and hearing a person's story. The notion of companionship roots in the Latin "cum panis," "with bread." Companionship grows through shared experiences of nourishment and nurturing, walking together, sitting quietly in conversation, having a meal together. It is not the giving or sharing of things that is important. Getting a cup of coffee, finding a pair of shoes, walking together to the shelter, accompanying someone to an appointment are occasions for being present and building a personal relationship. In companionship there is a deep acceptance of the other as they are. Companionship embraces the whole person, the illness, homelessness, ragged clothes, as well as the uniqueness, beauty, tenderness, history, gifts, and potential of this individual.

In companionship, trust grows to a point where plans can be made and others introduced to help with specific needs. The relationship experience nurtured in companionship becomes the ground for admitting others to the circle of care, as partners. In the phase of partnership, the healing team companion serves as a

continuing, crucial resource, but is someone who does not play an instrumental role in a person's life. The companion is there to encourage and reflect on and help the process of the emerging partnerships.

As a healing team comes into place with a person who has been homeless and mentally ill, as the partnership grows with others, the outreach and engagement effort moves into a final phase of mutuality. Companionship is deepened into a relationship of increasing equality and reciprocity. Both partners share in an increasing wholeness, neighbors sharing together a common community and human journey. Fear, confusion, stigma, judgments, estrangement, and distance are transformed in the direction of empathy and compassion.

The chaplain carries out a regular, daily round of outreach and engagement services, working with 40 to 50 people a year, and a dozen to 15 individuals at any given time. What are the community analogues of the outreach and engagement process? How can congregations and their members participate effectively and appropriately in assisting homeless, mentally ill individuals from the street to stability? Where and how can laity play a role in approaching and companionship persons experiencing mental illness, support the formation of caring partnerships, and truly welcome the estranged neighbor fully into the life of the community?

A first step has been to design and implement a Companionship Training Curriculum in both a six month and one day formats. The one-day training is

done ecumenically, to equip local church members for a door-keeping ministry. The doorkeepers are available on Sundays at their church with a special care for those who come in need or seek help and assistance. The training includes an introduction to homelessness, communicating with someone who is experiencing symptoms of mental illness, listening skills, hospitality, crisis intervention, and referral resources. Fourteen churches in the four neighborhoods have participated in the training and have Sunday doorkeeper companions. Trainings are offered three times a year. Each church organizes its own team of doorkeepers, which meet regularly for mutual support and on-going education. Persons who themselves have experienced mental illness or homelessness are encouraged to be a part of the door-keeping ministry. The Chaplaincy provides an on-call resource person to consult with questions or difficult situations.

This Sunday program was developed because most other resources are closed on Sundays. Folk from the street and people in need come to the one refuge they know is open, the church. In the absence of an intentional ministry of welcome and support, churches found themselves overwhelmed and ineffective in responding to the individual literally on their doorstep. Congregations expressed uneasiness, fear, insecurity, and ignorance about how to act with marginal folks in their midst.

Each church decides the extent of material aid it will provide to individuals on a case-by-case basis. Basic hospitality is offered-refreshment, rest, and simple hygiene resources. A common set of referral resources has been developed.

The Sunday companions are prepared to help secure food, shelter and medical care for the day. The churches have identified three drop-in centers downtown as inns where a person can be assured of respite and a place for the night. Sunday companions in the door-keeping ministry are practiced in introducing individuals to these resources.

The extended training is designed to equip laity to serve as community companions working with folks over the long haul either from a base in their own church or a base in a community agency or program. The final segment of the training introduces a process of discernment, in which individuals explore and test their calling to develop or participate in a particular ministry setting.

Plymouth Church in downtown Seattle has developed some 600 units of single room occupancy and low income housing in and around the downtown core. The aim of the mission is to preserve deteriorating housing from demolition or upscale development for those most in need. The most marginal tenants became increasingly unmanageable. Several of the early buildings offered the least expensive rents and housing. One was closed. A second remained open with the involvement of the Chaplaincy and a group of Plymouth Community Companions. An agreement was reached to set aside seven of the 32 rooms in the building for homeless, mentally ill individuals. A small community room was carved out in the building, which had no public gathering place. An associate

chaplain coordinated the admission of homeless, mentally ill individuals to the building with the on-site manager, and was present several days each week to visit each of the mentally ill residents and facilitate community building and informal after dinner discussion about resident issues, tenant needs, and life in the building and neighborhood. Companions assisted with a variety of outings, retreats and connections with neighborhood activities and events, and encouraged individual residents in their healing partnerships with caregivers.

The formula of community and self-support facilitated by the chaplaincy and the community companions became the model for a more extensive effort at the Gatewood, a 100 unit building dedicated exclusively to housing homeless persons. Community companions are actively engaged there, basing their efforts on a weekly Wednesday afternoon gathering of residents. Companions are present, but also share their experience in such areas as cooking, art, math and science, and literacy training as people have interest. Companions have accompanied residents to a variety of appointments, visited during hospitalizations, tutored, assisted with moves into permanent housing, and shared in outings. The Wednesday gathering has become a time of reconciliation and renewal by helping residents become acquainted with one another and opening up possibilities and encouragement for next steps.

Community Companions at Pilgrim Church have developed an ecumenical resource center, open during the week to help people negotiate the various agencies and programs needed to make the transition to stability. Gathering volunteers from other churches, the group instituted a caring neighbor's program developing vouchers redeemable at local businesses and social services to meet a wide variety of basic needs identified by homeless folks. Panhandling and community antagonism toward homeless individuals was reduced as cooperation among various stakeholders in the community increased in addressing the challenge of homelessness.

A vision of compassionate community has informed the development of the companionship program in local churches. The Chaplaincy has provided training and consultation, and occasionally initiated a specific service model in partnership with a local church, cluster of congregations or a community agency. The aim has been to act primarily as a catalyst, relying on existing institutions and appropriate structures in the community to help weave and maintain the fabric of long term. Ten years have been used doing education, laying groundwork, providing models and slowly nurturing grass roots elements of outreach, survival resources, transitional services and long term care.

FROM COMPANIONSHIP TO COMMUNITY ORGANIZATIONS

A guiding principle in the Chaplaincy's work has been that the organization of service and support be defined from the bottom up and from the edge in. We begin with those who are on the margin, and with those who have little or nothing. A small self-supporting group, including folks who themselves have been at the edge, is at the heart of each effort. Companionship is both the basic mode of service and the way of organization. The Chaplaincy, the Sunday doorkeepers and the community companions are collegial gatherings. A conveyor helps facilitate the meeting. Organizational gatherings most often occur over a simple meal. The occasion begins with prayer or some other meditative act. The group proceeds to reflect on scripture, some gift of art, traditional wisdom, or current commentary. There is good time for sharing, both about challenges, needs and concerns, but also about the personal and communal journey out of which we live and serve. The agenda grows from this process of centering, reflecting and sharing, and concludes with a period of discernment. Proposed actions are explored and tested. Each person in the group is considered to have an important voice. Decisions are taken by consensus. Those who have difficulty understanding or accepting a step or direction are honored as cautioning us to consider more carefully and deeply our plans and procedures. Each project is responsible for its own life and direction.

As companionship efforts have grown, and more churches and laity have become involved, new levels and forms of organizing in the community have evolved. An ecumenical working group has been formed to encourage collaboration among the Downtown and First Hill Churches in the door-keeping

ministry. The group is planning to expand the Sunday effort to the rest of the week. A single, common resource center was initially proposed, to which persons coming to any of the churches would be referred. The plan now is to deepen the capacity of each church to serve as an entry station to care, to refer well and effectively to existing resources, and to focus our creative efforts on filling gaps in care.

Need for emergency shelter and small scale transitional residences supportive of healing and convalescence have surfaced repeatedly. A member of doorkeeper teams has proposed a simple plan in which two or three retired or single folks would pool their rents for a home or apartment large enough to take in a guest or two. This informal, intentional community would welcome the person coming out of the hospital, or provide a first step off the street. A second concern is how to build community and be supportive of folks who continue to come by the churches. The plan is to collaborate in offering a variety of occasions for connection, from prayer and healing services, to simple meals, to vocational opportunities.

The religious community can provide a range of service of a Samaritan, innkeeping and supportive nature. Much of the care and resources needed by homeless and chronically mentally ill individuals, however, must be provided by the wider community and the public sector. We have been successful in having public health, human services and special needs populations, including homeless

and chronically mentally ill individuals, considered in the scope of work for neighborhood planning.

The hope is to have the neighborhood plans and citywide growth management documents address several key concerns. How will mental health information, outreach and triage services be made available at the neighborhood level? What public policy, procedures and funding decisions are necessary to insure a network of neighborhood scale survival, transitional and long term care services for the most difficult to serve chronically mentally ill individuals in our communities? In short, how do we organize neighborhood, city and regional life in such a way that homelessness ceases to exist for those among us with major mental illness?

We are building a small group of neighborhood advocates who are participating in the planning process. Ideas and suggestions are being brought back to and received from the groups working on the front lines and in the community. The experience and wisdom of those who have been on the margins and without care is being solicited and shared in the planning hearing and meetings.

GEEL, AN INSPIRATION

The effort to create compassionate community, able to welcome and support chronically mentally ill individuals, is a task of decades, even centuries. The Chaplaincy efforts have been criticized as Utopian, impossible of achievement. We take heart from the example of the community of Geel, Belgium. At the

center of the city is a psychiatric hospital. On the grounds of the hospital are small centers for vocational training in a number of economic areas traditionally reserved to those who experience major mental illness. The city is organized into five sectors fanning out from the city center. Each sector has a mental health house open from early morning to midnight. A healing team of psychiatrist, general practitioner, nurse, social worker and psychologist works from each house. Each team serves some 150 chronically mentally ill individuals living with more than 700 families in every neighborhood of the city. Each week the team nurse visits every home and patient. The team spends time each day with their patients in a variety of community activities - work, meals, sports, education, recreation, and service. Each day hospital and community staff meet to plan admissions and discharges. All hospital staff spend at least half a day each week with a community team and patients. Each community team member spends a half-day a week at the hospital.

The tradition of community care that is so richly developed in Geel emerged over a seven hundred-year history. Over the years stigma has been worn away. Understanding and patience have taken its place. Ways have been found to welcome and include. Healing is the calling of the whole community. In Geel, it is a privilege to be a host family, a privilege to provide a home for someone who is mentally ill.

Implementing the spirit of Geel in the American context and in a diverse, multicultural region is an enormous challenge. We have started, however, as the

people of Geel did in the 13th century. When they found mentally ill folks on the steps of their parish church, seeking aid, they took them in and offered such care as they could at the most intimate levels of their life, in their church, homes and neighborhoods.

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