

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

OFFICE OF THE MEDICAL DIRECTOR

4.15 ASSESSMENT AND INTEGRATION OF SPIRITUAL INTERESTS OF CLIENTS IN THEIR WELLNESS AND RECOVERY

Revised May 24, 2012

I. INTRODUCTION:

- A. The parameters provided in this document were developed by the Los Angeles County Department of Mental Health (DMH) with input from representatives of various groups, including the DMH Clergy Advisory Committee, to provide staff guidance as they inquire about and address the spiritual beliefs, needs, and practices of all clients and families as applicable to clinical work. This collaboration should be an integral part of mental health assessment, goals formulation, and treatment planning, but should never be confused with proselytizing. DMH employees, students, volunteers or contractors<sup>1</sup> (hereafter referred to as "staff"), are not permitted to proselytize under the auspices of the County of Los Angeles or the Department of Mental Health.
- B. Staff should have the skills to address the spiritual and religious interests, beliefs and worldviews of clients and families in order to integrate these into treatment goals whenever appropriate, recognizing that value-rich spiritual and religious concepts are often at the core of hope, wellness, recovery and the therapeutic processes.

II. DEFINITIONS:

- A. Family: Parents, siblings, children, spouses, extended family, foster family, life partner and other persons who are significant in a personal support system.
- B. Proselytize: To induce someone to convert to one's faith or spiritual beliefs.
- C. Religion: A set of beliefs and practices designed to help an individual or group express and carry out their spirituality. (Provided by the DMH Clergy Advisory Committee.)
- D. Spirituality: It is a person's deepest sense of belonging and connection to a higher power or transcendent life philosophy which may not necessarily be related to an organized religious institution. (Adapted from California Mental Health & Spirituality Initiative with input from the DMH Clergy Advisory Committee.)<sup>2</sup> Spirituality is a process of pursuing meaning and purpose in life (Marvin J. Southard, D.S.W., 2009).<sup>3</sup>

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<sup>1</sup> Refers to locum tenens and service staff who are directly contracted to work as part of DMH. It does not refer to staff of contract agencies.

<sup>2</sup> California Mental Health and Spirituality Initiative  
(<http://www.mhspirit.org/uploads/VALUESSTATEMENTRev2011-03-23.pdf>)

<sup>3</sup> Southard, M.J. (2009), The Connection Between Mental Health and Spirituality,  
([http://www.mhspirit.org/uploads/2009\\_conference\\_Dr\\_southards\\_speech-byline.revMJS060710.pdf](http://www.mhspirit.org/uploads/2009_conference_Dr_southards_speech-byline.revMJS060710.pdf))

- E. Worldview: "Worldview" refers to the manner in which a culture sees and expresses its relation to the world around it.<sup>4</sup>

### III. ASSESSMENT:

- A. Staff should sensitively inquire about the client's spirituality and/or religion. While this inquiry may be done at any time, staff should exercise professional judgment to assess the appropriateness of the inquiry. Staff should consider this inquiry as a part of an overall assessment and a critical component of identifying a client's strengths, challenges and resources in order to more fully understand the client's functioning.
- B. Staff should communicate their reasons for asking questions about a client's spirituality by incorporating the following practices:
  - 1. Discuss the importance of this information for ensuring culturally sensitive DMH services for the best treatment and recovery outcomes.
  - 2. Communicate that establishing a dialogue on this information is a matter of choice and not a requirement for DMH services, and that it will not be a basis for any form of discrimination or denial of services.
  - 3. Emphasize the non-judgmental nature of the mental health assessment and treatment; especially as it relates to spirituality and/or religion.
- C. Staff should assess key components of any spiritual or religious preferences and practices, including:
  - 1. The wish to include spiritual or religious practice information as part of the care planning.
  - 2. The meaning of spirituality to the client, including affinity to any specific spiritual or religious group/organization/practice.
  - 3. Any spiritual or religious concerns or conflicts involving the client and other members of the support system, or others involved in the client's life.
  - 4. Any involvement from a spiritual community that has resulted in the client's seeking and obtaining mental health services in the past.
  - 5. The role spirituality or religion may have previously played in the client's life.
  - 6. The role spirituality or religion currently has in the client's life, plans, or hopes, specifically as it relates to coping skills.
  - 7. Current sources of spiritual or religious comfort or guidance.

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<sup>4</sup> Barre Toelken, "Cultural Worldview." Dynamics of Folklore (revised and expanded edition), Logan: Utah State University Press, 1996. [263]

#### IV. TREATMENT PLANNING:

- A. Staff should include spiritual/religious dimensions as appropriate within treatment planning. For example:
  - 1. The consideration of culturally competent spiritual and religious issues in case formulations, treatment planning and the development of the Client Care Coordination Plan (CCCP).
  - 2. The inclusion of culturally relevant spiritual and religious support, resources and goals in recovery-based treatment planning.
  - 3. The coordination of contact, when desired and appropriate, with spiritual counselors or advisors of the client's choosing and, ideally, with the client present, and with the stipulation that the:
    - a. Client's consent should be obtained before initiating contact.
    - b. Contact is treated with cultural sensitivity and respect.
    - c. Outcome of such contact is noted in the client's clinical record.

#### V. BOUNDARY ISSUES:

- A. Staff should use sound professional judgment, taking into account personal, interpersonal and cultural effects on the client, when choosing to:
  - 1. Share personal spiritual or religious information;
  - 2. Support client's or family's spiritual or religious activities; or
  - 3. Participate in such activities with a client (e.g., religious wedding or coming of age ceremony, funeral, etc.)
- B. Under no circumstances should staff take actions that create an appearance of proselytizing.

#### VI. ADMINISTRATIVE ISSUES:

- A. DMH programs should act upon requests for specific services or available staff on the basis of spiritual or religious beliefs in an appropriate fashion, including:
  - 1. Affirming that a consumer's ability to choose his/her therapist is important and that consideration will be given to such requests.
  - 2. Clarifying that such requests will be honored to the degree possible.
  - 3. Affirming the non-discriminatory and ethical nature of service/support offered by staff.

- B. All DMH administrative and clinical activities, including any that are related to spiritual or religious practices or beliefs must comply with existing governmental regulations and recognized ethical and professional standards.

#### VII. STAFF TRAINING:

- A. Spiritual/religious assessment, case formulation and treatment planning should be a part of both clinical and cultural competence training on an ongoing basis.
- B. Topics covered by training should include:
  - 1. Important clinical and administrative issues related to spiritual and religious aspects of assessment and treatment.
  - 2. Definitions and explorations of spirituality, worldviews, and religious practices, as they relate to hope, wellness, and recovery.
  - 3. Discussion of therapeutic dynamics and cultural biases related to spirituality and religion.
  - 4. Discussion of the cultural context, relevance and variations in spirituality and religious practices in local and regional communities.
  - 5. Assessing the role of spirituality and religion in the life experiences and mental health of clients and families.
  - 6. Incorporating spiritual and religious beliefs and practices in case formulations, treatment planning, and overall treatment.
  - 7. Understanding and noting how clients describe the quality and meaning (essence) of their experiences as they relate to spiritual and mental health practices.

#### VIII. DMH PROGRAM RELATIONSHIPS WITH THE SPIRITUAL AND RELIGIOUS COMMUNITIES

DMH programs should:

- A. Maintain an avenue for receiving appropriate referrals from local spiritual and religious resources.
- B. Assist clients and families to connect with the spiritual and religious resources of their choice in the community as appropriate and specifically on the client's request.
  - 1. Staff shall not make formal referrals for clients to a specific spiritual or religious resource.
- C. Always be sensitive to the value of information provided by spiritual or religious advisors and to the disclosure constraints they may face.
- D. Inform spiritual and religious communities about available mental health services.

- E. Consult with the program manager if at some point staff learns that a specific religious practice the client is engaging in may be illegal or harmful to the client.

#### IX. REFERENCES:

- A. California Mental Health and Spirituality Initiative  
(<http://www.mhspirit.org/uploads/VALUESSTATEMENTRev2011-03-23.pdf>)
- B. Southard, M.J. (2009), The Connection Between Mental Health and Spirituality,  
([http://www.mhspirit.org/uploads/2009\\_conference\\_Dr\\_southards\\_speech-byline.revMJS060710.pdf](http://www.mhspirit.org/uploads/2009_conference_Dr_southards_speech-byline.revMJS060710.pdf))
- C. Toelken, B (1996). "Cultural Worldview." Dynamics of Folklore (revised and expanded edition), Logan: Utah State University Press, [263]

#### X. RESOURCES:

Listed below are some of the related informational resources.

- A. Cornah, D. (2006). The impact of spirituality on mental health: A review of the literature. ([http://www.rcpsych.ac.uk/pdf/Mental Health Foundation spirituality reportx.pdf](http://www.rcpsych.ac.uk/pdf/Mental_Health_Foundation_spirituality_reportx.pdf))  
"In the past decade or so, researchers across a range of disciplines have started to explore and acknowledge the positive contribution spirituality can make to mental health. Service users and survivors have also identified the ways in which spiritual activity can contribute to mental health and wellbeing, mental illness and recovery."
- B. Psychiatric Rehabilitation Journal, 2007. Volume 30, No. 4, 287-294.  
"Spirituality has been cited as having a positive effect on mental health outcomes. . . Results suggest that age, gender, having psychotic symptoms, having depressive symptoms, and having a higher global quality of life, hope and sense of community were all significant correlates of spirituality."
- C. Psychiatric Rehabilitation Journal, 2007. Volume 30, No 4. 247-249.  
"Emerging evidence about the beneficial impact of spirituality on recovery outcomes suggests that the successful incorporation of spiritual approaches into clinical practice has the potential to contribute to the next quantum leap in the development of effective, person-centered systems of care."
- D. Corrigan, P., McCorkle, B., Schell, B., & Kidder, K. (2003). Religion and spirituality in the lives of people with serious mental illness. Community Mental Health Journal, 39(6), 487–499. Corrigan, et al, suggests that spirituality holds unique promise in fostering recovery from psychiatric disabilities.
- E. Seybold, K & Hill P.C. (2001). The Role of Religion and Spirituality in Mental and Physical Health. <http://cdp.sagepub.com/content/10/1/21.short>  
An increased interest in the effects of religion and spirituality on health is apparent in the psychological and medical literature. Although religion in particular was thought, in the past, to have a predominantly negative influence on health, recent research suggests this relationship is more complex. This article

reviews the literature on the impact of religion and spirituality on physical and mental health, concluding that the influence is largely beneficial. Mechanisms for the positive effect of religion and spirituality are proposed.

- F. Corresponding Committee on Religion, Spirituality and Psychiatry, American Psychiatric Association (2006). Religious/Spiritual Commitments and Psychiatric Practice: Resource Document. Retrieved from <http://www.psych.org/Departments/EDU/Library/APAOfficialDocumentsandRelated/ResourceDocuments/200604.aspx>.
- G. Dein, S. (2010). Religion, Spirituality and Mental Health, Psychiatric Times, 27 (1). (<http://www.psychiatrytimes.com/display/article/10168/15098320>)
- H. Puchalski, C. (2001). Role of Spirituality in Health Care, Baylor University Medical Center Proceedings, 14 (4), 352-357. [http://findarticles.com/p/articles/mi\\_6802/is\\_4\\_14/ai\\_n28127920/?tag=content;col1](http://findarticles.com/p/articles/mi_6802/is_4_14/ai_n28127920/?tag=content;col1).