Wholeness Not Perfection

An Interfaith Framework for Mental Health

Texas Interfaith Center for Public Policy
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Mental disorders have been recorded throughout human history. One of the world’s earliest medical documents, the Ebers Papyrus (Egypt, circa 1550 B.C.E.) describes observed behaviors and symptoms similar to modern day depression or dementia. Over the millennia, people have crafted various treatments for mental health conditions – from drilling holes in patients’ heads, to casting out evil spirits, to talk therapy. While knowledge about mental health and treatment methods for disorders has expanded significantly, the stigma surrounding them remains.

Faith communities were some of the first groups to provide systematic care to those with mental disorders, and they are still involved with mental health care today. Clergy are often the first source of help sought by someone with a mental health disorder. As such, religious communities have an important and unique role to play in mental health care.

In this publication, we explore the call to religious communities to care for the needs of individuals and families affected by mental illness, take a look at the current state of mental health care, and offer ideas about what you and your congregation can do to help. We hope to inspire you to reflect on what it means to be healthy and whole, and to encourage you to examine why people with mental disorders often feel unwelcome in our communities.

**Created in Relationship**

“It is not good that man should be alone; I will make him a helper as his partner.” Genesis 2:18

According to the Hebrew Scriptures, all people were created b’zelem Elohim, in the image and likeness of God, and are therefore worthy of dignity and respect. Catholic social teachings affirm that people with mental illness always bear God’s image and likeness; God’s image is neither
Illness and Culture

The form that illness takes can vary between cultures or historic periods. Culture can be illustrated as the behaviors and beliefs characteristic of a particular social, ethnic, or age group.

For example, there is an illness, amok, particular to Southeast Asia where a man has “an episode of murderous rage followed by amnesia” and an illness called zar in the Middle East expressed in “dissociative episodes of laughing, shouting, and singing.” In Europe during the late 1800s, doctors documented an illness characterized by men walking for hundreds of miles in a state of amnesia. These illnesses were recognized only by their particular culture or time period.

Certain constellations of symptoms may be shared between cultures, but manifest themselves in different ways. The World Health Organization estimates that 121 million people worldwide have depression and list it as one of the leading causes of disability. Symptoms of depression typically include sadness, hopelessness, and lack of energy. In Asian cultures, however, depression is often expressed as a physical ache or pain that has no identifiable source.

The World Health Organization estimates that 24 million people worldwide have schizophrenia. Common symptoms include auditory, visual or somatic hallucinations, delusions, flat emotionality, and significant impairments in cognitive functioning.

Interestingly, the type of hallucination and the contents of delusions that individuals report seem to be related to their culture. For instance, “in Japan, a country that prizes honor and social conformity, delusions often revolve around slander or the fear of being humiliated publicly. In Nigeria, where mental illness is believed to be caused by evil spirits, delusions may take the form of witches or ancestral ghosts.”

Sometimes, symptoms typically associated with mental illness are instead associated with religious experience. People from various religious backgrounds report hearing the voice of God, seeing visions, and feeling touched by someone or something they cannot see. While all of these experiences qualify as hallucinations, they are not typically interpreted as evidence of illness unless accompanied by serious impairments to functioning.

Culture affects not only the way people manifest symptoms of mental illness and what they consider to be illness, but also affects “their style of coping, their support system, [and] their willingness to seek treatment.” Research has shown that African Americans are often reluctant to seek treatment for mental illness for themselves or family members. Reasons given include a history of oppression and mistrust of those in power, heightened stigma about mental illness within the community, and a lack of African American mental health providers.

---David B. Morris, Illness and Culture in the Postmodern Age

Imagination, narrative, and other human meaning making activities have an inescapable role in constructing the experience of someone who is ill.

--David B. Morris, Illness and Culture in the Postmodern Age
**The Medical Model**

The United States and much of the Western world embraces an understanding of mental health based on the medical model. Under the medical model, a disease or disorder can be defined as a deviation from normal body functions that creates negative consequences in an individual. In general, the medical model considers disease as being within the confines of the individual’s body, and does not highlight the influence of external forces or conditions. Symptoms of disease, such as abnormal behavior, point to an underlying physical abnormality. Mental illnesses are viewed as disorders of the brain that have physiological, biochemical, or genetic roots.

A classification system has been developed for mental health disorders called the Diagnostic and Statistical Manual of Mental Disorders (DSM). A mental disorder, as defined in the DSM IV, does not require a purely physical cause, but is considered a “manifestation of a behavioral, psychological, or biological dysfunction in the individual.”xxv This definition encompasses the medical model but incorporates other theories on abnormal behavior.

A diagnosable disorder is considered severe when it results in serious functional impairment that substantially interferes with an individual’s ability to function in his or her community, family, workplace, and other social settings.xxvii Disorders that tend to be severe and chronic include schizophrenia, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, and post-traumatic stress disorder. Each of these illnesses alters a person’s thoughts, feelings, and/or behaviors in distinct ways.xxviii In contrast, some mental disorders are acute and temporary, such as anxiety or mild depression, often brought about by intense stress in an individual’s life.

Under the current medical model, health is largely considered the absence of disease, and attaining health is focused on curing disease. The primary treatment method for mental disorders is medication, which targets the underlying neurological and biochemical causes. After medication, if a person’s symptoms do not subside or if the symptoms intensify, the medical model offers little hope for a return to health.

Today, mental health professionals including psychiatrists, psychologists, and social workers provide treatment that expands beyond what the medical model can offer. Some providers also incorporate spirituality and religion into their treatment. In fact, the American Psychological Association requires that training programs include education in spiritual and religious concepts.

make him a helper as his partner,” so God creates animals and then the first woman (2:18). This creation story illustrates two fundamental religious beliefs shared by the Abrahamic faith traditions of Judaism, Christianity, and Islam: one, that human life originates from and is sustained by God, and two, that it is not good for human beings to be alone. Humankind was created in relationship with God, with the whole of creation, and with other people.

The shape that God’s relationship takes with humans in the Hebrew Scriptures is one of covenant. In the first covenant, God instructs humans to “be fruitful and multiply, abound on the

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*Some philosophers and psychiatrists have suggested that we are investing our great wealth in researching and treating mental illness, medicalizing ever larger swaths of human experience, because we have rather suddenly lost older belief systems that once gave meaning and context to mental suffering.”*  
--Ethan Watters, “The Americanization of Mental Illness”
earth and multiply in it,” and God promises that there will never again be a flood that destroys the entire earth (Gen. 9:7). The instruction to humans to be fruitful encompasses more than mere reproduction, and suggests the idea of human flourishing. This idea is echoed in the Christian New Testament when Jesus says, “I came that they may have life, and have it abundantly” (John 10:10). Human beings are not created merely to exist, but to be fruitful and to flourish. In Genesis, God affirms the value of the entire creation by calling it “very good” (1:31).

The Buddhist tradition believes that humans are fundamentally good and compassionate beings at their core, and that all life is connected, such that “I am you and you are me.” From the Buddhist perspective, awakening to the realization that all life is intimately connected revives one’s core nature. The Hindu system of yoga teaches that one of the primary causes of suffering is ignorance of our true nature and our relationship with Divinity. In fact, the word yoga means union.

Broken Relationship

“He was so terrible that he was no longer terrible, only dehumanized.” --F. Scott Fitzgerald, “Tender Is the Night”

Stigma is apparent in the way people talk about mental illness and in the way people encounter – or avoid – those with mental disorders. Stigma is a central barrier between people and treatment.

The dictionary defines stigma as “a mark of disgrace or infamy; a stain or reproach, as on one’s reputation.” A medically oriented definition of stigma is “a mental or physical mark that is characteristic of a defect or disease,” as in the “stigma of leprosy.” The word is taken from the Latin where it means a tattoo or brand placed on a criminal.

Some studies have shown that identifying mental disorders as abnormalities of the brain has resulted in increased stigmatization of those with such disorders. Symptoms of certain mental disorders, such as disordered thinking or other impairments in functioning, directly confront Western notions of personhood that center around reason, rationality, and self-determination. Labeling an individual with a diagnosis of mental disorder can overwhelm the individual’s identity—
Mental Health Care: A History Lesson

Over the centuries mental health care has evolved from hiding individuals with mental disorders in basements and treatments of starvation to usage of behavioral health centers with psychological counseling and holistic health treatments.

The earliest cultures understood the causation of mental disorders to be supernatural powers, metaphysical entities, or witchcraft; treatment centered on religious rituals, herbs and ointments, charms and prayers, and acupuncture. Some early communities viewed mental disorders as a direct result of a problem with an individual’s relationship with God, while others identified positive aspects of mental disorders such as prophesying and artistic inspiration.

In the Middle Ages, the growth of Islam brought new ideas and concepts of mental disorders. Islamic teaching connected mental disorders to a loss of reason, and writings covered links between the brain and disorders. Texts from this period contain discussions of mental disorders such as mania and delusions and proposed treatments. The first psychiatric hospital was established in Baghdad in 705, and the construction of “insane” asylums followed in the early 8th century. Treatment and protection of individuals with mental disorders was humane and focused on therapeutic techniques such as baths, drugs, music, and activities.

In Europe, Christian theology dominated the view of mental disorders during the Middle Ages. Concepts of mental disorders revolved around the divine, demonic possession, and magic. Mental disorders were viewed as a moral issue, either a punishment for sin or a test of faith. Early European treatments consisted of purges, bloodletting and whipping; fasting and prayer for those estranged from God; and exorcism for demonic possession. The infamous Bethlehem Royal Hospital – a psychiatric hospital in London better known as “Bedlam” – opened during the Middle Ages. Bedlam remains the historical exemplar for inhumane and brutal treatment of individuals with mental disorders, going as far as to promote public viewings and mockery of patients in their cells.

By the end of the 18th century the widespread view of “madness” shifted to the concept that a mental disorder was an organic physical phenomenon, not involving the soul or moral responsibility. New treatment options for disorders using physical and psychosocial techniques were prevalent. Some techniques were considered humane,

“Many cultures have shown a tendency to depersonalize those who have some form of serious disability, whether of a physical or a psychological kind. A consensus is created, established in tradition and embedded in social practices, that those affected are not real persons.”

--Tom Kitwood, “Dementia Reconsidered: the Person Comes First”
such as hiring sensitive attendants, but most techniques like bloodletting and forced vomiting were not. Due to the emerging classification systems of medicine and biology, scholars and experts began to devise schemes to classify mental disorders. The 19th century brought a shift in public perceptions of individuals with mental disorders and their treatment, leading to the “mental hygiene” movement, aimed at “preventing the disease of insanity” through public health strategies and clinics. The term “mental health” arose from this era, and the professions of psychiatry, clinical psychology and social work developed. The Society of Friends (Quakers) provided a strong voice for more humane treatment of individuals with mental disorders. The Quakers practiced a method of care known as “moral treatment,” an approach based on humane care and moral discipline that helped to lay the foundation for modern psychiatric medicine in the U.S. xxxvii

Congress passed the National Mental Health Act in 1949, which provided federal funding for psychiatric education and research. This Act led to the creation of the National Institute of Mental Health (NIMH) followed by the Community Mental Health Act of 1963. Further advancements in the field occurred with the enactment of Medicaid and Medicare, enabling low-income Americans to access mental health services.

The mid 20th century also saw advances in treatment options. Treatments such as psychotropic drug therapy, lobotomies, insulin shock therapy, and electro convulsive therapy helped to facilitate the transition of the mental health care system from an institution-based state and national system to a local, community-based system. The ensuing closure of many state hospitals resulted in the movement of many severely mentally ill people into local communities that often were ill-equipped to meet their needs.

The results of deinstitutionalization are mixed. The movement of individuals with mental disorders from in-patient facilities to community centers meant increased demand for care and coordination of services that many local communities could not provide. Individuals with unmet mental health needs became and remain disproportionately likely to enter the criminal justice system or become homeless. On the other hand, community-based services—in addition to being less expensive for the public—allow individuals with mental disorders to remain in familiar settings near their families and other systems of support.

What sort of religion can it be without compassion? You need to show compassion to all living beings. Compassion is the root of all religious faiths. Hindu. Basavanna, Vacana 247.
calling them “schizophrenic” rather than a person “with schizophrenia,” for example—leading to feelings of worthlessness or abandonment by God and others. Many people with mental disorders wrestle with excessive guilt and shame, retreating into isolation rather than sharing their struggle with others. Stigma has the effect of compounding the distress that people experience. In fact, shame and isolation may have an even stronger negative effect on well being than a person’s underlying condition. Mental illness can be understood as the leprosy of the modern era. Biblical scriptures on leprosy help illuminate that connection. The Torah says that “the person who has the leprous disease shall wear torn clothes and let the hair of his head be disheveled; and he shall cover his upper lip and cry out, ‘Unclean, unclean.’ He shall remain unclean as long as he has the disease; he is unclean. He shall live alone; his dwelling shall be outside the camp” (Lev. 13:45-46). The scriptures say that anyone who touches a leper becomes unclean (Num. 22:4-5).

“Healing is impossible in loneliness; it is the opposite of loneliness. Conviviality is healing. To be healed we must come with all the other creatures to the feast of Creation.”

Wendell Berry, “The Art of the Commonplace: The Agrarian Essays”
Today, many people with mental disorders report positive experiences with faith communities. However, there are still those who have negative experiences such as feeling judged or being excluded. Separation from faith communities, paired with the fact that some individuals with severe mental disorders become incarcerated or homeless, reveals to us that many people with mental disorders end up living “outside the camp.” Sometimes, religious communities go beyond excluding individuals with mental illness and cause harm to the mental health of their congregants. Just as in any other institution or relationship, the power and authority that clergy and other religious leaders hold in people’s lives creates the potential for abuse. Religious abuse takes place when a

The Gift of Being Human

Is mental illness a gift? Some people think so, and links have been drawn between mental disorders and creative genius since the 4th century B.C.E. Plato believed that “madness, provided it comes as the gift of heaven, is the channel by which we receive the greatest blessings....Madness comes from God, whereas sober sense is merely human.” Famous scientists, theologians, religious leaders, athletes, writers, actors, politicians, musicians, and artists all make the list of people with serious mental disorders. Several research studies have linked creativity and mental illness to similar, underlying structures in the brain. Consider that one common reason that people give for avoiding use of psychotropic medications is that these medications alter brain function, dulling creativity and, thus, personality.

“The wound is the place where the Light enters you.” —Rumi

While some consider mental illness a gift, others feel that calling it a gift minimizes the pain and suffering that is experienced as a result of such illness. What faith communities can affirm is the giftedness of each individual, whether giftedness is related to mental illness or not. A Jewish rabbi, the Maggid of Zlatcov, said that “it is the duty of every person to know and consider that he is unique in the world in his particular character and that there has never been anyone like him in the world.” The Christian apostle, Paul, said “there are varieties of gifts, but the same Spirit,” (1 Cor. 12:4). Faith communities can help every member of the community realize his or her unique character and gifts for the good of the whole.

“Being human is difficult. Becoming human is a lifelong process. To be truly human is a gift.” —Rabbi Abraham Heschel

Rather than condemning mental illness as an aberration or idealizing it as an acceptable cost of divine inspiration, faith communities can offer a more nuanced approach. We can affirm that diversity is a part of God’s creation, that people have different ways of experiencing the world, that there is no “normal.” By sharing our different experiences, we can come to understand the full depth and breadth of what it means to be human. We can affirm that none of us are perfect, that we need one another to be whole. Theologian Stanley Hauerwas said that we are created for one another and that incompleteness makes possible our gifts.

“The Gift of Being Human”
person or institution claims to be speaking for or acting as God commands, yet perpetuates verbal, emotional, physical or sexual abuse of others. In Biblical times, illnesses like leprosy were commonly understood to be the result of sin, a punishment from God. This is a view that has been expressed by all of the Abrahamic religions. The Islamic tradition has also viewed illness or disease as a divine test of the level of piety, devotion, and loyalty that a follower has to his or her faith. Today, many followers of these religious traditions still share these views, though there are others that hold alternative views. Some base their conception of illness on the story of Job in the Hebrew Bible. Job was a man afflicted with leprosy and much misfortune through no fault of his own.

One modern theologian describes sin as “profound estrangement.” James B. Nelson writes, “It is relational brokenness, separation from everything meaningful. It is alienation from ourselves, from those around us, and from our environment. It is separation from life itself. Fundamentally, it is estrangement from God, the source and ground of all that exists.” When the faith community’s fears or preconceptions lead to the exclusion or dehumanization of people with mental health conditions, then this can intensify a person’s experience of “profound estrangement.”

Buddhists teach that a boundary between self and others is a false distinction, a false construct of the mind. The Buddhist practice of meditation centers on raising a person’s awareness of his own thought pattern of forming judgments and separating himself from others. The fruit of meditation is to realize that individuals may be thought of as waves, but they all part of one ocean; that, in fact, all life is interconnected.

Illness and Religion

While many religious traditions affirm that mental disorders have a biological basis, most speak of the health and healing needed for individuals who suffer from such disorders in a different manner. Jewish and Christian scriptures contain no exact word for health—although there are health-related concepts within the Bible like shalom. One theologian describes shalom as “the webbing together of God, humans, and all creation in justice, fulfillment, and delight.... We call it peace but it means far more than mere peace of mind or a cease-fire between enemies. In the Bible, shalom means universal flourishing, wholeness and delight—a rich state of affairs in which natural needs are satisfied and natural gifts fruitfully employed.”

Health as shalom speaks to the wholeness and flourishing of the entire creation; it is focused on more than the individual.

Healing, from a religious viewpoint, “represents a tradition’s deepest hopes and promises....It may take the form of enlightenment, salvation, a place in Heaven, life in a World to Come, Paradise, Nirvana, freedom from cycles of rebirth, immortality, sagehood, venerated ancestral status, remaining alive in human memory.” These concepts provide individuals and communities with an ultimate frame of reference within which to “interpret all other experiences, including the meaning of health in this lifetime.”

From a religious standpoint, healing may involve curing, but it is concerned much more with the ultimate meaning and purpose of life.

Religious interpretations of illness are diverse. There is particularly wide variability in theological understandings of mental illness both within and between religious traditions. Mental illnesses are viewed as a reflection of a fallen creation, as a result of individual disobedience or collective sin, as part of God’s design, as the result of possession by evil spirits, or as part of the human condition that everyone shares. Mental illnesses are experienced as blessings, as a means of growth, as curses, or as the cause of immense human suffering. At times throughout history, respected rabbis, prophets, and theologians have exhibited behaviors many would find symptomatic of mental illness today.

People of faith wrestle with “why” and “what for” questions. These are important and difficult questions; however asking who we are called to be and how we are called to be in relationship with people affected by mental illness may ultimately be more valuable and lead us toward greater community health and wholeness.
Healing Relationship

Created in—and for—relationship, human beings are not meant to be alone. The book of Ecclesiastes says: “Two are better than one, because they have a good reward for their toil. For if they fall, one will lift the other; but woe to one who is alone and falls and does not have another to help. Again, if two lie together, they keep warm; but how can one keep warm alone?” (4:9-11).

People with mental disorders cannot flourish in isolation, alienated from others. They need community, and the community needs them. Buddhism describes four kinds of good friends: one who helps, one who is constant in good times and bad, one who points out what is good for you, and one who is sympathetic. There is a Sikh saying that “only those persons are my friends who can walk along with me.”

Islam and many other religious traditions recognize that the health of an individual is related to the health of the whole community. In Hindu thought, the well-being of the individual is considered foundational for the well-being of society. Karma, or the good or bad emanations resulting from one’s actions, is collective as well as individual; an individual’s manifestation of illness may reflect the energies of the greater society. Jewish tradition teaches that each person is so important, that saving one person’s life is like saving an entire world. In the New Testament, the Christian apostle, Paul says, “If one member [of the church] suffers, all suffer together with it; if one member is honored, all rejoice together with it” (1 Cor. 12:26). Similarly, the Buddhist tradition says that all people suffer, and all people are at one. If the world is to flourish, then all who are in it must flourish.

Compassion and empathy, or love, form the basis for healing, wholeness, and human flourishing in many religious traditions. There is an Islamic saying that “you shall not enter Paradise until you believe; and you shall not believe until you love one another.” Based on the Torah, Christians teach that God’s ultimate commandment is to “love the Lord your God with all your heart, and with all your soul, and with all your mind,” and to “love your neighbor as yourself” (Matt. 22:37-40).

Jainism teaches: “Have benevolence towards all living beings, joy at the sight of the virtuous, compassion and sympathy for the afflicted, and tolerance toward the indolent and ill behaved.” An early Christian apostle instructed members of his church: “Do nothing from selfish ambition or conceit, but in humility regard others as better than yourselves. Let each of you look not to your own interests, but to the interests of others” (Phil. 2:3-4). This kind of love is focused on both the needs and the virtues present in others. It looks for the best in others. This kind of love can only take place when people spend time together and know one another. A community grounded in mutual love makes healing possible.

What Can Congregations Do?

Faith communities sometimes abdicate their role in healing to physicians, psychiatrists, or other health professionals. Mental health professionals offer a particular kind of expertise, focusing primarily on understanding and treating biological and psychological disorders. Many now

“The Divine Presence dwells where there is love and peace generated by friendship.” --Rabbi Abraham Weinberg of Slonim
recognize the need for spiritual care, too. Religious traditions have something unique to contribute to the healing process. People of faith are particularly equipped to help individuals find meaning and wholeness in the midst of their illness.

Religious leaders can help individuals and families reframe their experience in light of the sacred wisdom of the tradition, encouraging movement toward peace, forgiveness, and wholeness. They can help individuals struggle through the profound spiritual questions that mental disorders may raise, they can affirm the sacred worth of individuals with mental disorders, and they can offer teachings and prayers to help people move toward wholeness.

Faith communities can provide stories and models that give shape to people’s suffering. For example, the laments of the Hebrew Bible offer a model for relating to God during times of crisis or grief. For Christians, Jesus is God-with-us who understands what it is to suffer and be abandoned by God. Faith communities can provide rituals, practice, prayer and meditation that help provide peace and stability to someone living with a mental disorder. Most of all, congregations can provide friendship, community, and acceptance.

There are symptoms of mental disorders that can, at times, be disruptive to communities—and while most mental disorders do not result in violent behaviors, some do. It is appropriate for faith communities to set boundaries around the kinds of behaviors that are acceptable at community gatherings; however, behaviors related to mental disorders should not be used as an excuse to exclude particular individuals. Faith communities are encouraged to make a commitment to remain open and find creative ways of keeping individuals with mental disorders connected to the faith community.

**Connecting the Whole Community**

Congregations have a unique role in shaping the entire community in which they are located. In the realm of mental health, congregations not only have the opportunity to educate and establish inclusion practices within their religious communities; they also have the opportunity to better the mental health system as a whole.

Faith leaders and congregations can better the system in a multitude of ways. At the local level, opportunities include becoming connected and working with local mental health centers, participating in local issue-forums that explore both the challenges and positive aspects of the mental health system, partnering with local hospitals to provide programs and support for mental health community centers, and joining local boards and focus groups.

Alongside connecting with mental health providers and networks, congregations and faith leaders can connect with health care system decision-makers like local government officials, state agency officials and legislators. When discussing issues facing the state, faith leaders often provide a much-needed voice, one with experience and a background that is different from that of the decision makers.

What follows is a list of some of the principles that can guide faith communities in the area of working with individuals and families living with mental illness:

**Learn.** Faith leaders can learn about common mental disorders, symptoms, treatments, and strategies to work with those affected by them. They can raise awareness about mental disorders throughout their community during times of prayer, worship, religious education, or other community-wide gatherings and through

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**“There is no worship, no music, no love, if we take for granted the blessings and defeats of living.”**

--Abraham Joshua Heschel

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Navigating The System

The term mental health care is used in various contexts to cover a wide variety of services, ranging from family counseling to the prescription of anti-psychotic drugs for schizophrenia. The “system” a fragmented network of programs, services, and payments through which individuals access care. The mental health care system is separated from physical health care and substance abuse care systems. This separation often makes it difficult to know where and how to get assistance.

There are four categories of mental health providers: highly trained specialists such as psychiatrists, psychologists, and psychiatric nurses; providers with training in general health care such as family practitioners, pediatricians, and nurse practitioners; social service providers such as school-based counselors and criminal justice workers; and informal volunteers, such as peer counselors, that generally have neither formal training nor a license to treat mental or physical health services. Many religious-oriented providers are social service workers or volunteers.

The mental health care system is intertwined not only with the physical health care system, but also the criminal justice, educational, and housing services systems. As a result, mental health professionals, individuals with mental disorders, and their families often refer to the mental health care system as a confusing maze.

The first step for an individual accessing mental health services is often a referral for a mental health assessment. Family members, emergency room attendees, school counselors, primary care physicians, social workers, and a variety of other professionals in varying capacities make referrals for assessments. For example, if a child is experiencing symptoms, a counselor at school might recommend an assessment by a professional at a community health center or by the child’s pediatrician. A person entering the correctional system may have a mental health assessment as part of the intake process.

Initial assessments are conducted by an array of professionals who then discuss and analyze before deciding on treatment options and providers. Once assessed and diagnosed by a professional, an individual with a mental disorder is quick to discover that health insurance is a needed resource for receiving care.

Health insurance coverage for mental illness is often less comprehensive than for physical illness. This disparity includes complete non-coverage, higher copayments, and lower treatment limits for mental disorders. Lower income individuals turn to financing options, sliding scale payments, and Medicaid and Medicare for mental health services and coverage.

Hospitals often are overcrowded and lack open beds, causing long waiting lists for services. Hospitals sometimes refer individuals to community centers, viewed by many experts to be ideal for the treatment of mental disorders. Unfortunately, not all communities have the resources to provide a local mental health care facility, and if they do, there is frequently a lack of qualified, culturally competent employees to staff the center.

Severe mental disorders and lack of available services have led to an increase in public costs related to crime and criminal justice, homelessness, and uncompensated health care. State budget cuts for mental health programs have increased costs for local governments. The combination of deinstitutionalization, inadequate community mental health programs, and limits imposed by private insurance plans have increased the likelihood that individuals with mental disorders will end up in the criminal justice system or experience homelessness.

Today, the criminal justice system is the de facto provider of last resort for individuals with untreated mental disorders. The federal government estimates this population to make up about 16 percent of the jail and prison population.

Correctional facilities, mental health professionals, hospitals, local providers and lawmakers encounter the same maze of frustrations that individuals with a mental disorder encounter. State mental health professionals not only assist with treatment options, but also connect individuals to basic needs such as housing or income assistance. Often, mental health professionals at the state level maintain long working hours and a multitude of patients or clients. Hospital challenges center on a lack of resources, beds, staff, and finances. Legislators must make difficult decisions about mental health, from the allocation of resources, to policies in the criminal justice system, to mandates related to health insurance.
Wholeness, Not Perfection

Support. Families of people with mental disorders and establish wellness programs and worship services focused on healing. There are a lot of resources available to help in this endeavor. The extent to which a particular faith community can offer direct services or programs will depend on their size and budget.

Partner. Mental health professionals, state agencies, community health centers, and nonprofit organizations can offer valuable insights in identifying symptoms and working with people with mental disorders. They often act as referral sources when someone needs help beyond what the faith community can offer. Some mental health organizations are faith-based and provide spiritual care that is integrated with mental health care.

Advocate. Faith communities can advocate for policies and programs that provide better access to services for uninsured individuals with mental disorders. They can advocate for systematic improvement to the system of mental health care in Texas and the nation, improving the lives of people with mental disorders.

In learning about someone different than ourselves, we come to understand more what it means to be human. In choosing language that affirms, rather than separates, we move toward wholeness. In connecting with the community and mental health system as a whole, we learn how to best assist those in need. In showing compassion to someone living with mental illness, we bring more peace, love, and joy into the world.

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A believer who participates in human life, exposing himself to its torments and suffering is worth more than the one who distances himself from its suffering.

--Islamic Hadith of Ibn Majah
SOURCES
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