The Impact of the Faith-Based and Community Initiative on Rural Mental Health Care

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Abstract

President George W. Bush established the Office of Faith-Based and Community Initiatives in 2001 and eventually, by executive order, set a precedent for federal agencies to revise their policies to allow faith-based organizations to apply for federal grants. This initiative made over three billion dollars available to organizations that had heretofore been prohibited from accessing public funds due to their religious affiliation. As the initiative has developed, there seems to be a predominance of evangelical and fundamentalist Christian organizations involved in the projects that public funds support including services to those with mental illness. Evangelical and fundamental Christian ideology includes strong beliefs that people's problems are often the result of moral failure and the solution to many of life's problems lies in accepting Jesus Christ as Lord and Savior. Viewing mental illness as moral failure has damaging implications for people with mental illness and for the public's understanding of mental illness. Additionally, the faith-based initiative is grounded in the principles of privatization, thus shifting services to those with mental illness into the private sector. As services are privatized, the fragile system of public mental health care in rural areas is often diminished or eliminated. Research shows that mental health professionals have a long history of practicing largely in urban areas, thus reducing the likelihood that private providers will serve rural areas. If, through the faith-based initiative, care for the mentally ill in rural areas is left to religion-based organizations, many people who have very complex biologically and environmentally based disorders may be left with limited, non-existent, or potentially harmful care. This paper examines some of the complex questions and issues raised by the faith-based and community initiative as related to mental health care.

The Impact of the Faith-Based and Community Initiative on Rural Mental Health Care

In 2001, the President of the United States, George W. Bush, created the White House Office of Faith-Based and Community Initiatives (OFBCI). Its purpose was to discover barriers that prohibit Americans in need from receiving effective social services. By August of 2001, the OFBCI issued its report entitled *Unlevel Playing Field*, which identified regulatory and administrative barriers that discriminated against faith-based and community groups in the Federal grant process. After Congress failed to come to a consensus on proposed legislation, President Bush issued an executive order in December of 2002 that directed federal agencies to revise their policies so that "equal treatment" principles are followed in grant making. Essentially, this order began a movement to allow religious and faith-based organizations to apply for federal grants through several federal departments without having to "secularize" themselves as had heretofore been required. Bush's actions paved the way for religious organizations to access over 3 billion tax dollars via federal programs. Over the past five years, more than 20 states have established faith-based offices or liaisons that are working with religious and/or faith-based organizations to access State funding for specific social service projects. Additionally, at the local level, more than 180 Mayors have also established similar

offices, including the Mayors of Philadelphia, Miami, San Diego, and Denver[1]. From its beginning, the faith-based and community initiative has been controversial and it remains so as secularists express fears that tax dollars will be used to fund efforts to "convert" non-religious people and religious groups express fears that certain faith traditions will try to utilize tax dollars to gain more members[2]. Some questions are raised in the fray: Will the government identify "legitimate" religions or faiths by deciding who gets money and who does not? Can the government effectively monitor the use of tax dollars to ensure that they are used for social service programs instead of furthering a particular religious agenda? Will the collaborative approach employed by the Bush administration with religious organizations undermine the United States' Constitutional foundation of separation of church and state? While there are no easy or clear answers to these questions, they provoke us to examine the impact of the paradigm shift away from separation and toward collaboration with regard to the tenuous relationship between religion and government. In particular, as religious groups engage in delivering social services, including services for people who are mentally ill, one is compelled to evaluate the impact on such services and, more importantly, on the people who receive them.

The debate surrounding the causes of mental illness is ages old and in the past 100 years, it has been greatly influenced by the emerging field of social science known as psychology and by the medical specialty of psychiatry. Currently, most in the academic community would argue that mental illness is rooted in disorders of the brain, and that medically based treatment is optimal. In the United States, a recent study by the Centers for Disease Control revealed that the most frequently prescribed medications are antidepressants, in particular, the selective serotonin reuptake inhibitors[3]. There are many other medications whose purpose is to treat mental illness, suggesting that there are biological factors in mental illnesses. In fact, many mental problems that were once thought to be character defects are now framed as brain disorders or chemical imbalances and the United States Congress is currently debating legislation that would place

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[1] FCCH Political Transcripts. "George W. Bush Delivers Remarks at the White House National Conference on Faith-based and Community Initiatives", as released by the White House, (FDCH Item No. 32V00369297690), (Washington, DC: Whitehouse, 2006)

[2] Jo Renee Formicola, Mary C. Segers, and Paul Weber, "Faith-based Initiatives and the Bush Administration: The Good, the Bad, and the Ugly", (New York: Rowman & Littlefield Publishers, Inc., 2003).

[3] M. Fox, "U.S. Hospital, Doctor Visits Balloon", Survey Finds Scientific American, http://www.sciam.com/article.cfm?alias=us-hospital-doctor-visits&chanId=sa003&modsrc=reuters, (2007), (accessed July, 2, 2007).

some mental illnesses on par with medical conditions in terms of insurance reimbursement. Additionally, there are many varieties of "talk therapies" that are offered to people who suffer from a range of mental and emotional disorders, with clinical social workers comprising the largest group of mental health service providers[4]. Best practice models suggest that a combination of medications and talk therapy seem to be the most effective treatment for mental disorders[5]. Services for those with mental illness are driven by the medical model – where an assessment prompts a diagnosis and a service plan - with diagnosis of mental illness being dictated by the American Psychiatric Association's Diagnostic and Statistical Manual, currently in its fourth edition with text revision.

From the mid 1800s until the 1940s, mental health treatment was largely delivered by medical staff at hospitals that usually specialized in mental health treatment. Most of those institutions were large and often state supported, with people being admitted for long lengths of stay. Modes of treatment during the era of asylums and institutions included insulin shock therapy, hot and cold "tub" treatments (hydrotherapy), lobotomy, psychoanalysis, and behavioral modification, as effective medications had not been developed. When lithium and chlorpromazine (thorazine) came into existence in the early 1950s, the treatment of mental illness was forever changed and the relationship of mental illness to biological factors was solidified. This, coupled with the call to reform the mental asylums, began to shift beliefs about mental illness from stigma and silence to public discussion and a better understanding that mental illness was not a moral issue, but rather a medical one[6]. The shift from institutional to community- based treatment of mental illness culminated in President John F. Kennedy signing into law the Community Mental Health Centers Act of 1963. This was legislation that mandated the use of federal funds to establish community-based mental health treatment centers with the intention of providing community-based care rather than institutional care to those with severe and persistent mental illnesses. While the effort was thwarted because of the Vietnam War, the idea of community-based care was alive and well at the grass roots and local levels; thus, the community system of care was developed during the 1970s. Unfortunately, many of the so-called "walking well" overshadowed the treatment of those with severe mental illness because of

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[4] National Association of Social Workers, (2007).
[5] HHS News, (1999).
[6] Ann Palmer, "20th Century History of the Treatment of Mental Illness: A Review", http://www.mentalhealthworld.org/29ap.html (accessed June 23, 2007). Hereafter know as Palmer.

the high demand for help with substance abuse and emotional difficulties. Urban areas enjoyed more services than rural areas largely because of the availability of professionals. The movement to empty the large mental institutions was in full force and deinstitutionalization was at its height by the mid-1970s, with many severely mentally ill people finding themselves discharged from long-term care in institutions to a newly developing community care system that was under-funded and hardly ready to absorb the numbers coming from the institutions. While the Carter administration made an attempt in the early 1980s to extend substantial federal funding to community mental health care, the Reagan administration significantly reduced the funding[7]. The movement to privatize mental health care gained momentum during the late 1990s largely as a result of criticism about wasteful government spending and, consequently, public mental health care is currently transforming as services are being delivered by the private sector, with many people who have no insurance being unable to receive services.

For the past 40 years, the treatment of mental illness and mental disorders in the United States has been delivered largely through a mix of public and private sector organizations and agencies. As mentioned above, the private sector is now absorbing those who had previously been served in the public sector. While there is a long tradition of religion-based service delivery in most social service areas[8], and though many mental health agencies are rooted in religious organizations, a majority of contemporary services to people with mental illness has been delivered by organizations that follow very secular policies and practices largely as a result of the progress that has been made in biological and psychological research regarding mental illness. The relationship between mental health and religion is ancient, and modern scientific beliefs about mental illness have developed as a result of research intended to disprove the long-held idea that mental illness is a morally based problem.

People with mental illness have long been viewed by many religious communities as possessed by something evil or as having immoral flaws of character. In fact, many in some religious groups continue to believe that faith is a key to solving mental and emotional problems. In fact, President Bush has said, "This initiative [referring to the Faith-Based and Community Initiatives movement] recognizes the power of faith in helping to heal some of our nation's

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[7] Palmer.

[8] Bob Wineburg, "A Limited Partnership: The Politics of Religion, Welfare, and Social Service", (New York: Columbia University Press, 2001).

wounds. I have faith that faith will work in solving the problems"[9]. Bush critiques the ability of the government to be effective in the social service and mental health arenas, as evidenced by his statement delivered at the National Religious Broadcasters meeting in 2003, "The role of the government is limited, because government cannot put hope in people's hearts or a sense of purpose in people's lives. That happens when someone puts an arm around a neighbor and says, "God loves you""[10]. Though President Bush has stated that all religious organizations, regardless of tradition, are welcome to apply for grants through the faith-based initiative, many critics have observed that those from Christian traditions seem to be targeted as purveyors of the funds made available by the initiative[11]. Certainly, President Bush makes no secret of his own religious convictions as a conservative Christian and many of those in his administration often profess their faith in fundamental or evangelical Christian beliefs. Kaplan observes that most of those in attendance at the 2003 White House Conference on Faith-based and Community Initiatives were Christian and, in fact, "Every single religious presenter, handpicked by the faith-based office as a model for 'successful partnerships,' represented a Christian outfit…"[12]. At the center of evangelical Christianity is the drive to win souls to believe in Jesus Christ as the Lord and Savior of the World. Central to the belief in Christ is the idea that the burden of your problems can be given to Christ, thus relieving you of pain and suffering in this world as you are secure in the knowledge that you will go to Heaven and reap your reward of eternal life. A central tenant in evangelical Christianity is that people are inherently sinful and morally corrupt; therefore, without turning to Jesus, a person is lost forever with an eternal destiny to burn in the fires of Hell. The assertion is that while none of us become sin free, Jesus bears the burden of our sins and gives us hope for everlasting life in Heaven. Morality in evangelical Christianity is defined by acts of goodness and kindness linked with helping the lost find Christ, for without having

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[9] Ron Hutcheson, "Bush to Bypass Congress on Faith-based Charities", para. 2,
    http://www.philly.com/mld/philly/4718731.htm?template=contentModules/printstory.jsp (2002), (Accessed May, 13, 2007).

[10] Ester Kaplan, "With God on their Side: How Christian Fundamentalists Trampled Science, Policy, and Democracy in George W. Bush's White House", (New York: The New Press, 2004), p. 40. Hereafter know as Kaplan.

[11] Kaplan.
Bob Wineburg, "Faith-based Inefficiency: The Follies of Bush's Initiatives", (Westport, CT: Praeger Publishers, 2007).
Jo Renee Formicola, Mary Segers, and Paul Weber, "Faith-based Initiatives and the Bush Administration: The Good, the Bad and the Ugly", (New York: Rowman & Littlefield Publishers, Inc, 2003). Hereafter know as Formicola.

[12] Kaplan, p. 42.

Christ in one's life, all hope is extinguished. It is this link between charity and saving souls that becomes a concern when considering evangelical Christian organizations as providers of mental health services and other social services, particularly when one considers the burdens borne by those with mental illness including stigma, discrimination, and public fears about violence and aggression. There seems to be an underlying belief that the solution to social and mental health problems is, "… an evangelical one: find Jesus and life will change"[13]. There are many anecdotal cases where a fundamentalist Christian minister suggested that a congregational member with mental illness stop his or her medication and surrender to the Lord for healing – a scenario that is apparently not uncommon in rural areas where fundamental Christianity seems to be more prevalent. The guidelines for receiving funds through the faith-based and community initiative program are clear in their prohibition of these of funds for "religious worship, instruction, or proselytization"[14]. While the rhetoric of the faith-based initiative includes much about the prohibition of evangelizing and proselytizing, assessing the extent of how much it is involved when religious organizations are delivering social and mental health services is very difficult if not impossible.

The historic connection between social work and religion continues to exist despite the secularization of the social work profession in the 20th century. Large organizations such as Catholic Social Services, Jewish Family Services, and Lutheran Family Services continue to engage social workers as the deliverers of mental health and other social services. According to a study by Sheridan and Amato-Von Hemert[15], there is growing evidence that religion and spirituality are experiencing a surge in professional beliefs about their roles in social work practice. Additionally, Sheridan and Amato-Von Hemert[16] discovered, to their alarm, that a majority of the 208 social work students they surveyed believed that religion and spirituality had a role in social work practice and many of them endorsed the use of religious or spiritually oriented intervention strategies in social work practice despite the lack of exposure to the topic in their educational programs, which may imply potential harm to clients. Most certainly, there are

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[13] Formicola, p. 173.

[14] "Guidance to Faith-based and Community Organizations on Partnering with the Federal Government", http://www.whitehouse.gov/government/fbci/guidance_document_01-06.pdf (Accessed June 10, 2007), (2006), p. 10.

[15] Michael Sheridan and Katherine Amato-Von Hemert, "The Role of Religion and Spirituality in Social Work Education and Practice", *Journal of Social Work Education*, vol. 35, no. 1, p125-141, (1999). Hereafter known as Sheridan

[16] Sheridan.

mental health professionals who hold strong religious beliefs and some of them may see the faith-based initiative as a signal to use their beliefs with government endorsement. After all, if the government is allowing religious organizations to receive federal funds, why would the government not allow religious beliefs to be utilized in delivering the services those funds support? Indeed, if one closely examines the message of the Bush administration, it seems imperative to use religion and faith to lead people out of social and personal ills. Tirrito and Cascio[17] point out that social work education continues to shy away from religion as a central player in the lives of clients and social work practitioners. Until mental health and social service professionals engage in ongoing exploration, discussion, and dialogue about the role of religion and spirituality, we can expect a limited understanding of the importance of religion and we may see harmful practices being purveyed with vulnerable people who need more than a moral change in their lives.

Many experts believe that it is not immorality that causes social problems and mental illness; rather, such concerns are complex with roots in economic inequality, biology, and environmental stressors related to issues of poverty and oppression. Additionally, it does not seem to be moral failure that is the largest problem facing social service agencies; rather, it is a lack of adequate funding, resources, and support[18]. Resources are particularly problematic in rural areas where local funds are scarce and services are, at best, very basic for those with mental illness. In the public community system model, mental health services were made available in many areas that lacked resources and providers of services. As services have been privatized and the public system has been dismantled, rural areas are being left with limited or no resources for mental health care. It is estimated that in 2006, 80% of master's-level social workers and 90% of psychologist and psychiatrists in the United States worked exclusively in metropolitan areas, reflecting a 30 year pattern of such a distribution among this specialized workforce[19]. Despite many efforts to lure mental health professionals to rural areas, there has not been much progress in increasing the numbers of practitioners who are willing to relocate or commute to non-urban locations. When practitioners work in a rural area, they are often asked to intervene outside their scope of practice, make complex clinical decisions without the benefit of collaboration, engage

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[17] Terry Tirrito and Toni Cascio, "Religious Organizations in Community Services: A Social Work Perspective", *(*New York: Springer Publishing Company, 2003).

[18] Formicola.

[19] J.A. Gale and D. Lambert, "Mental Healthcare in Rural Communities: The Once and Future role of Primary Care", *NC Medical Journal* vol. 67, p. 66-70 (2006). Hereafter know as Gale.

in non-clinical roles with clients, and become subject to professional isolation which may result in burnout[20]. The foundation of the faith-based initiative is to enhance the privatization of social services and, as services become more privatized, there is less likelihood that mental health professionals will want to practice in rural or poor areas, particularly when their livelihoods depend on the ability of their clients to pay for services either privately or through third party reimbursement. Many have argued that the specialty care system that has existed in mental health care has contributed to the lack of care in rural areas. There are other factors that have limited mental health services, including beliefs and attitudes about mental health concerns being moral or character faults of the individual rather than stemming from biological or environmental systems based etiology. The United States Congress continues to struggle with mental health parity legislation which would create equal insurance reimbursement rates for mental and physical illnesses. Currently, insurance companies are not required to reimburse for services to people with mental illnesses on an equilateral basis with physical conditions, resulting in higher co-payments to providers and, obviously, more costs to the person receiving services. Insurance companies often limit the amount of reimbursement they provide in a lifetime for mental illness, which can result in a depletion of insurance coverage in the midst of treatment or termination of coverage for a severe and persistent disorder.

Stigma about mental illness remains as one of the primary challenges for those who have mental illnesses, as well as for advocates for the mentally ill. Much of the progress against the effects of stigma has been made as a result of the scientific view of mental illness as a disease with biological origins, implying that the person suffering from a particular disorder is unable to simply correct his or her morality in order to resolve his or her problems. The view of mental illness as an illness by the general public is fragile, and shifting services to the mentally ill into private, religion-based agencies has the potential to support and expand the view that what people with mental illness need is a good dose of religion rather than medication and other treatments that may help to stabilize their conditions. Many rurally based religious organizations do not seem to be seeking to establish mental health services and in fact, the Rural Assistance

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[20] Gale.

Center[21] (RAC, 2007) lists only six "success stories" with regard to faith-based services in rural areas around the country. While the RAC list is not exhaustive, it indicates that rural areas can not and should not depend on faith-based organizations to meet the needs of those with mental illness. There are calls to include mental health care with primary medical care in rural areas and, while there have been some efforts on the part of government to create incentives for this effort, the need for mental health care continues to expand far beyond the expansion into the existing primary medical care system.

Most certainly, religious organizations have historically played and currently continue to play a vital role in caring for the poor, the disenfranchised, the needy, the sick, and the mentally ill. Many religions have as a central principle the importance of charity and giving. For some, religion is an important factor in coping with life's difficulties, including mental and emotional distress. Arehart-Treichel[22] points out that Philippe Huguelet and his colleagues studied the role of religion with people who had psychosis and found that 85% of the subjects indicated that religion was an important part of their lives and that 71% of those in the study thought that religion had helped them cope with their psychosis. While 54% said they believed that religion helped diminish their psychotic symptoms, 10% said that religion increased their psychotic symptoms and 14% felt that religion had a negative impact on their illness and lives. This study, one of the first of its kind, points to the significance of religion for people with mental illness and compels further exploration of this topic. The faith-based and community initiative offers an opportunity for religious organizations to become more established in the service arena and there are many people who need services for mental illness that would benefit from the religious component that may be offered in conjunction with professional services; however, not all would benefit from the religious aspect. Of utmost concern is how religious content may influence or harm people who are vulnerable. An article by Monkerud [23] points out that in the state of Texas, where President Bush began faith-based initiatives while he was Governor, the outcome of some

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[21] Rural Assistance Center, "Success Stories by Topic",
http://www.raconline.org/success/success_topic_details.php?topic=Faith-based, (2007), (Accessed on July 3, 2007).

[22] Joan Arehart-Treichel, "Religion Not Always helpful to those with Schizophrenia", *Psychiatric News* vol. 41, iss. 22, http://pn.psychiatryonline.org/cgi/content/full/41/22/22, (Accessed on July 3, 2007), p.22.
[23] Don Monkerud, "Faith No More", http://www.inthesetimes.com/comments.php?id=105_0_2_0_C, (2003), (Accessed July 2, 2007). Hereafter know as Monkerud.

of the state-supported faith-based programs is not positive, giving examples of dramatically higher rates of complaints in religion-based agencies as compared to state-licensed facilities as well as examples of state funded programs whose missions included evangelizing recipients, buying bibles with state funds to "find employment through a relationship with Jesus Christ;" a residential drug treatment program for teens who had no credentialed counselors or chemical dependence services with failure to inform residents of their rights and illegally handled medications; and a program for pre-release prisoners which encouraged "the spiritual and moral regeneration" of offenders[24]. Monkerud[25] says that the Texas Freedom Network (comprised of over 7500 religious and community leaders) has stated that "Texas already has a record with these policies [state supported faith-based initiatives]. We know that faith-based initiatives violate the religious freedom of people in need. In Texas, our record shows that the faith-based initiative also puts people in danger"[26]. With limited oversight and unclear methods for accountability, it is easy to envision a faith-based system of care that may, with the best intentions, create a plethora of harmful and damaging services for people with complex and difficult mental illnesses, particularly in rural areas where practitioners are challenged to stand alone in many instances. It is true that many government services are laden with bureaucratic red tape and certainly administratively top-heavy systems of care are not the ideal in service delivery; however, one of the positives to emerge in secular, government-controlled systems has been an emphasis on accountability and on quality. Private systems, unless they are regulated to become accountable or unless they elect to develop a transparent system of outcomes, may flounder in providing efficient, high quality services. The faith-based and community initiative does not offer clear systems for measuring or enforcing regulations or accountability measures, a problem that puts those receiving such services in jeopardy.

At this point in its life, it is difficult to assess the applied impact of the faith-based and community initiative program on rural mental health care, as measures are not in place for such an assessment; however, when the roots of the faith-based and community initiative are examined, one is left with some important questions about the base of the initiative in evangelical Christianity and about the controversies that have emerged in areas where faith-based services have been funded by tax dollars. Central to the consideration of the impact of

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[24] Monkerud, p. 2.
[25] Monkerud.
[26] Monkerud, p. 3.

faith-based services for people with mental illness is the ideological discourse around morality, biology, and environment with regard to mental illness. If we regress to a place where mental illness is generally believed to be a moral deficit, the advances that have been made with regard to understanding the complexity of biopsychosocial and spiritual human development become jeopardized, leaving those who live with mental illness in a precarious position. Faith communities are rich in their human and fiscal resources with regard to serving the disenfranchised, the mentally ill, and other vulnerable people, but are they willing to serve with an appreciation and celebration of the diversity of those who seek their services? Will faith-based organizations develop methods of accountability and hold themselves to a high level of quality? Will faith-based organizations in rural locations be willing and/or able to engage in the provision of services to those in their communities? These questions will be central as we engage in ongoing dialogue about the future of human services and mental health care, and its delicate relationship with faith-based organizations.

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