Mental Health Care Access: Anabaptist Responses to a Discriminatory System

Christine Guth

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Associated Mennonite Biblical Seminary

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Mental health care in the United States is available through a diverse and minimally coordinated collection of public and private services and facilities.[1] At its best, this patchwork of services has problems with coordination among the various parts. However, as vulnerable people sometimes discover, there are big holes in the patchwork—gaps in care that make it difficult or impossible for some people to access the care that they need. This paper examines issues of economic justice pertaining to access to mental health care. The examination takes the form of considering how representative Mennonite and Amish organizations have responded to the needs of people with mental illness—responses that take place within a wider health care system that openly discriminates against such illnesses. The three organizations I studied take diverse roles of involvement in mental health care: Oaklawn provides mental health services to the public, MMA[2] provides health insurance to Mennonite and other Anabaptist groups, and Rest Haven provides residential care to members of the Amish community following a psychiatric hospitalization.

[1] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Chapter 6: "Organizing and Financing Mental Health Services/The structure of the U.S. Mental Health Service System" (Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999), retrieved November 25, 2006 <http://www.surgeongeneral.gov/library/mentalhealth/home.html>.

[2] MMA began as Mennonite Mutual Aid but the organization now uses only the initials.

I begin by suggesting a biblical and theological basis for providing care for those with mental illness, followed by a few comments on the state of mental health care in the United States. Then I report on interviews with key administrators of Oaklawn, MMA, and Rest Haven. These interviews provide a window into services these organizations have chosen to offer, parameters that shape the organizations' responses to mental illness, and ethical choices they have faced. I supplement these administrator interviews with the perspectives of two representative families: one a consumer of services from Oaklawn and a second with health insurance through MMA. Following each interview report, I raise several questions that highlight ethical considerations and dilemmas raised by the interview.

Biblical and theological perspectives on responding to mental illness

In Mark 5:1-21, Jesus enters the Gentile country of the Gerasenes and immediately encounters there a man whose erratic and uncontrollable behavior has resulted in his living among the tombs. The narrator identifies the man as having an unclean spirit, which provides an explanation for his living among tombs, unclean home of unclean spirits. His community perceived him as a danger and had done their best to restrain him with shackles and chains, but to no avail. In the world of the story, those whose behavior was unexplainable and uncontrollable had to be removed from the community, to keep them from endangering others, either physically or spiritually.[3] The man evokes no fear in Jesus, who meets him with compassion and dignity, not attempts to overpower him. After sending away the occupying spirits, Jesus sends the restored man home to his own people, where the man proclaims to anyone who will listen all that Jesus has done for him.

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[3] Bruce J. Malina and Richard L. Rohrbaugh, *Social-Science Commentary on the Synoptic Gospels* (Minneapolis: Fortress Press, 1992), 182-183, 208.

The Gerasene man is a symbol of the suffering that we who have a psychiatric illness experience. Like us, the Gerasene man suffers both from internal turmoil and from how he is treated by others. Regardless of our beliefs about the possibility of demonic activity, ostracizing persons with mental illness does not embody the restorative, healing presence of Christ. In our contemporary world, knowledge we have gained about brain disorders means that we no longer need to call medically treatable mental illness demonic. We no longer need to treat persons with mental illness as if they personify evil. Yet social response to mental illness in our society is still governed too much by ancient fears and lack of understanding.

A significant part—perhaps even the most significant part—of Jesus' ministry to the Gerasene man is restoring him to human community, first with Jesus himself and eventually with his own people who had formerly feared and ostracized him.[4] The church continues Jesus' work of healing and restoration today when our communities offer dignity and compassion to persons with mental illness and allow them (or us) to retain or regain places of full integration within our communities.

Singling out disorders of the brain as deserving of less care continues the ancient practice of ostracism. Such discrimination against mental illness is sin, I suggest, because it perpetuates unnecessary suffering. Both the social stigma and systematic discrimination against mental illness are formidable barriers to accessing the treatment that can alleviate suffering. Former First Lady Rosalynn Carter argues that parity in the way mental illnesses are treated in our economic systems would end the stigma that sets apart these illnesses and the people who have them as less

[4]World Council of Churches, *A Church of All and for All—An Interim Statement* (Geneva: World Council of Churches, 2003), retrieved November 26, 2006, <http://www2.wcc-coe.org/ccdocuments2003.nsf/index/plen-1.1-en.html>, paragraphs 38– 39.

deserving of care.[5] Economic justice for persons with mental illness requires ending both attitudinal and systematic discrimination that exists against such illness. I believe God invites Christians to participate in creating this justice.

Mental health care in the U.S.

In the United States, mental health care needs are addressed by a variety of practitioners in a diverse array of public and private facilities and services known as the de facto mental health service system.[6] The publicly funded parts of this loosely coordinated system have historically provided care for those with the most serious mental illnesses. Availability of public sector care for the most serious mental illnesses has given room for private insurers to minimize their risk by covering only acute care for less impaired persons. Some insurers exclude coverage for mental health entirely; others impose substantial restrictions on mental health compared with somatic health coverage. Thus, mental health services require greater out-of-pocket expenditures, and persons with mental illness risk catastrophic financial loss when benefits run out.[7] Mental health parity legislation in recent years has attempted to require insurers to cover mental illness on the same basis as somatic illness, but its progress in achieving parity has been limited.[8] This has led to a topsy-turvy situation in which often one must live in deep enough poverty to qualify for public aid in order to receive adequate services to treat mental illness,[9] and most of those who have private health insurance are unprotected from catastrophic loss due to mental illness.

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[5] Quoted in *Shadow Voices: Finding Hope in Mental Illness,* prod. Burton Buller., ed. Wayne Gehman, *video* recording (Harrisonburg, Va.: Mennonite Media, 2005).
[6] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Chapter 6: "Organizing and Financing Mental Health Services/The structure of the U. S. Mental Health Service System."
[7] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Chapter 6: "Organizing and Financing Mental Health Services/History of Financing and the Roots of Inequity,"
[8]National Mental Health Association, *It Is Time to Pass Comprehensive Health Insurance Parity!* (Alexandria, Va.: National Mental Health Association, April 2005), retrieved November 25, 2006 <http://www1.nmha.org/state/parity/index.cfm>.
[9] Laurie Nafziger, personal interview, October 25, 2006.

As a consequence, many with mental disorders have little access to mental health care because they have inadequate discretionary income to pay for services out of pocket. Only about one-third of those who have a diagnosable mental disorder receives treatment in a given year.[10] In addition to the barrier of expense, the stigma of getting help for mental illness may be prohibitive, or the bureaucratic obstacles to receiving public aid may be too challenging to surmount. Family support for negotiating the complexities of accessing help may be unavailable or exhausted.

Persons with serious mental illness who receive no treatment, in my estimation, are what drive public response to mental illness, such as it is. More than half of all incarcerated persons have symptoms of a mental illness.[11] Serious mental illness is five to six times more prevalent in the homeless population than in the general population.[12] The National Alliance on Mental Illness (NAMI) argues, "State legislators and policymakers must realize that cuts to vital services for people with serious mental illnesses raise rather than reduce overall costs to society. These cuts affect systems in a very negative way. Corrections systems, indigent care systems, emergency medicine, or homeless service providers are left to pick up the pieces."[13]

Compassion toward persons with mental illness is low in the priorities of lawmakers, taxpayers, voters, insurers, and employers. The expense of incarceration and the nuisance of homelessness provide what impetus there is to care for those who are most seriously ill. Those

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[10] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*, Chapter 2: "The Fundamentals of Mental Health and Mental Illness/Overall Patterns of Use."

[11] Doris J. James and Lauren E. Glaze, *Bureau of Justice Statistics Special Report: Mental Health of Prison and Jail Inmates* (Washington, D.C.: U.S. Department of Justice Office of Justice Programs, September 2006), 1, retrieved November 26, 2006, <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf>.

[12] National Resource and Training Center on Homelessness and Mental Illness, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, *Get the Facts,* "Question #3: Why are so many people with serious mental illness homeless?" retrieved November 26, 2006, <http://www.nrchmi.samhsa.gov/facts/facts_question_3.asp>.

[13] National Alliance on Mental Illness, *Grading the States 2006*, "Policy Recommendations: 1. Increase Funding Tied to Performance and Outcomes" (Arlington, Va.: National Alliance on Mental Illness, 2006), retrieved Nov. 8, 2006, <http://www.nami.org/Content/NavigationMenu/Grading_the_States/ Recommendations/Policy_Recommendations.htm>.

with mental illness who pose little public threat or nuisance are mostly left to fend for themselves and to suffer in isolation if their income does not allow out-of-pocket payment for treatment. Since private insurance does not experience the cost of failed care, it tends to offer little coverage for mental health care except as compelled by law, instead deflecting the expense to the public sector or to the individuals and families directly affected.

Former U.S. Surgeon General David Satcher sums up the state of mental health care access in the U.S.: "Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services…. A key disparity often hinges on a person's financial status; formidable financial barriers block off needed mental health care from too many people.…We have allowed stigma and a now unwarranted sense of hopelessness about the opportunities for recovery from mental illness to erect these barriers. It is time to take them down."[14]

Mennonite and Amish Responses to Mental Illness

As a way to consider ethical issues involved in responding to mental illness within the contemporary U.S. environment, I interviewed administrators from three Mennonite and Amish organizations that are involved in varied ways in mental health care: Oaklawn, MMA, and Rest Haven. The environment in which these organizations work sets limits and conditions on how they are able respond to mental illness. Along with an organization's decision to become involved in mental health care comes the obligation to comply with parameters imposed by the wider systems in which the organizations participate. These external parameters shape the environment in which administrators make ethical choices and limit the range of those choices.

[14] David Satcher, "Preface," *in* U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General*.

This is most true for Oaklawn and MMA, because the services they have chosen to provide are highly controlled by government regulations and by market competition. Rest Haven is less closely integrated into the wider health care system and market economy; as a result, it receives fewer benefits from the wider health care system and operates with relatively greater freedom with respect to external controls. Yet it also operates within boundaries set by external regulations.

Oaklawn: a mental health service provider

Mennonite interest in responding to mental illness emerged during WWII when groups of Mennonite conscientious objectors to military service were assigned to serve in state mental hospitals. Horror at the conditions they encountered inspired efforts to establish several community mental health centers under Mennonite sponsorship.[15] Oaklawn, one of these centers, operates within the U.S. de facto mental health care system to provide direct services, both outpatient and inpatient, to persons with mental illness. Oaklawn's experience reflects the hope, the frustration, and the ambiguity of responding to difficult situations with finite resources.

Oaklawn claims on its website a "faith-based heritage" and a commitment to treat "the whole person—mind, body and spirit." These elements contribute to "a unique foundation for healing and hope."[16] To learn more about Oaklawn's role in providing access to mental health care, I interviewed Laurie Nafziger, newly appointed President and Chief Executive Officer of

[15] Paul D. Leichty, "Mennonite Advocacy for Persons with Disabilities," 195–205 in *Disability Advocacy among Religious Organizations: Histories and Reflections*, ed. Albert A. Herzog (Binghamton, N.Y.: Haworth Pastoral Press, 2006), 197.
[16] "Hope and Healing Begin Here," homepage of Oaklawn, Goshen, Ind., retrieved November 26, 2006 <http://www.oaklawn.org>.

Oaklawn. I also conducted an interview by telephone with Hal Loewen, who retired from the same role in September after thirty-five years of service to Oaklawn.[17]

Nafziger described some of the ways Oaklawn expresses its heritage of faith: “About 30 percent of our gross revenue goes to charity care. We expect to give away about one-third of the care we provide, so we build our budgets expecting those kinds of write-offs.” Thus, when persons who have no insurance come seeking outpatient services, Oaklawn is able to offer outpatient care on an ability-to-pay scale. Those needing inpatient care will get the services they need and will not be turned away. Nafziger and Loewen admit that Oaklawn is least able to serve those who are “just beyond the boundary.” These are people who are too well off to qualify for public funds, but who have inadequate insurance and no discretionary income to pay for care on their own.

Nafziger affirmed that the care they offer has improved: “The people we are able to help now we are helping better than ever before. Medications have gotten better and have fewer side effects. Few people need to be institutionalized. We talk in the field now about recovery—not just better functioning, not just stabilization, but recovery. We work at treating the systems that surround the person who is ill, bringing to the table families, teachers, church members, and others who interact with the person with mental illness.”

Nafziger acknowledged that access to mental health care is not equitable. “There *is* no mental health parity,” she asserted. “Mental health parity is a long, slow battle that we will fight for a long time.” She noted that public attitudes toward mental illness are an obstacle to obtaining funding for mental health care. “Our society treats mental illness as if it is not a real disease, as if mental health care is an optional extra. We are at the bottom of the feeding chain. There is money for cancer and heart disease. This is where hospitals are building new buildings.”

[17] Laurie Nafziger, personal interview, October 25, 2006; Hal Loewen, telephone interview, October 28, 2006.

In Loewen's opinion, mental health parity is likely to remain restricted as long as there is insufficient evidence to support which treatments are most likely to be successful.

"We don't have the luxury of brainstorming about what services we'd like to offer," Nafziger admitted. "We have to start with what will be paid for. This changes over time. Things swing back and forth. The good news is that there are many different ways to offer mental health services." She noted the frustration of being pressed by "warring interests within the government; one part of the government promotes good practices while another part tries to cut budgets."

When I asked about the points where she makes ethical decisions, Nafziger implied that the environment they must work in presents them with difficult choices. "As we consider what kind of staff to hire, what kinds of programs to run, we always have to consider the payor. That feels crass. We hate to feel like we are being driven by what will pay. When it comes to decisions about how long to keep a person in care, we try to give our staff the freedom to do what the patient needs, yet we can't be blind to the payor."

In response to my inquiry about access to mental health care, Loewen emphasized that access to care is available; however, there are definite limits in the kind of care available. Since most of Oaklawn's income comes from some governmental source, public policies have a major influence on the kinds of treatment they can offer. The services people are asking for may not be the most effective treatment or the most efficient use of funds. He pointed out that Oaklawn faces the challenge of drawing on limited resources to serve a large population and thus must find approaches that are the most effective for the least expense so that more people can be served. The implication is that ethical provision of mental health care must be efficient in its use of public funds so that more people who need care can receive it.

Loewen believes that managed care, despite some abuses, has brought needed accountability and responsibility to mental health care. Under pressure to reduce costs, Oaklawn has transitioned from a psychotherapy model to a medical model of treating mental illness and from high-cost individual therapy toward lower cost group therapy and self-help groups. “Some services are frivolous,” Loewen contended. “Managed care taught us to look at what is effective and efficient, because there is not enough money to pay for all the services that are out there.”

Loewen sees the need for community accountability in making health care decisions. “We haven’t known how to put the boundaries on [unnecessary expense] as a society. We make healthcare decisions in isolation. As Anabaptists, we look for simplicity and try to make judgments together that are sound for the community of faith.” “Community is essential in matters of mental health care ethics,” Loewen emphasized. “We need a broad range of perspectives in order to discern together what kinds of care make the most sense.”

Naming it as an expression of Anabaptist values, Loewen affirmed Oaklawn’s recent efforts toward involving a person’s community in the plan for ongoing care. Although the community-based recovery model reflects Anabaptist principles, Loewen believes that churches, ironically, are often ill prepared to participate in these communities of support: “The average congregation’s priorities do not include any health care, and mental health care is even lower.” When building community support, “we have to go where we get the most response for our effort.”

Christians committed to economic justice for persons with mental illness might reflect on the following questions:

Who or what should determine which people may access “expensive” forms of mental health care, or are such options never appropriate?

Is psychotherapy an optional luxury only for those with the discretionary income to finance it personally?

How can congregations be more effective in providing the community support that persons with mental illness need for recovery?

MMA: a provider of health insurance

MMA contributes to the patchwork of U.S. mental health care through providing health insurance that offers a limited mental health benefit. As it does, it participates in the highly regulated U.S. health insurance industry. Regulations that vary state by state, along with market competition, set boundaries within which MMA must work as it seeks to offer ethical financial choices to Mennonites and related groups. At MMA, I interviewed Steve Garboden, who is Interim President, Chief Executive Officer, and Vice President of Health and Administrative Services and Rollin Handrich, Health Member Services Manager.[18]

When I asked Garboden and Handrich to describe ethical issues MMA has considered in relation to equitable access to mental health care, Garboden called attention to Mennonites' history of working in the mental health field. This historical and ongoing commitment has encouraged MMA not to abandon mental health coverage under market pressures. As other health insurance companies have moved in recent decades to reduce or eliminate mental health coverage, Garboden explained, MMA has chosen to retain a comparatively generous mental health benefit in individual health plans—a lifetime limit of $40,000.[19] Most competitors have changed to annual limits—of $1,000 to $2,500—if they cover mental health at all. Although in the industry a $40,000 lifetime limit for mental health is considered generous, one may note how it compares to the $5,000,000 lifetime limit for somatic health conditions in the same plan.[20]

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[18] Steve Garboden and Rollin Handrich, personal interview, November 6, 2006.

[19] Garboden and Handrich noted that this figure and others in this section are approximate because states may stipulate limits, which vary from state to state.

[20] Garboden and Handrich use the term "physical health" to mean health conditions other than mental health. I suggest that this terminology unintentionally contributes to implicit discrimination against mental illness. In agreement with *Mental Health: A Report of the Surgeon General*, I affirm that mental health *is* physical health, the physical health of a particular organ in our body, the brain. Except in direct quotations, I follow the Surgeon General Report's recommendation that *somatic health* is a more appropriate term; (U.S. Department of Health and Human

Recognizing that one day of Oaklawn hospitalization costs an average of $1,100 [21] gives some idea of what such benefits will cover when an illness requires hospitalization. MMA has been able to further express its interest in providing mental health benefits in its decision to cover expenses related to self-inflicted injuries (suicide attempts).

In the mid 1980s, MMA began underwriting for health insurance. Underwriting serves as a means to exclude costs that would otherwise drive up the cost of a product. Persons may be excluded from coverage entirely or denied coverage for specific conditions. Without underwriting, healthy people were taking their business to a cheaper plan, leading to ever-higher costs for the unhealthy people remaining in the plan. Market guidelines for underwriting exclude from mental health coverage anyone with a mental health history. In the mid 1990s, Handrich explained, MMA collaborated with providers and others to write less stringent underwriting guidelines specific to MMA that evaluate the stabilization of the illness.

Garboden pointed out that with respect to underwriting, MMA operates with parity, since mental health and somatic health conditions are weighted equally for underwriting decisions. Nevertheless, he noted that for theological reasons he dislikes MMA's need to deny some persons coverage. Underwriting reflects a departure from the pure mutual aid of MMA's origins in traditional Anabaptist practice. My observation is that those who have been excluded or who become aware of such exclusion tend to blame MMA for abandoning mutual aid. Mutual aid carries a price that many have been unwilling to pay. A broader perspective would recognize that Mennonites and other constituent groups abandon mutual aid when they comparison shop for health insurance on the open market. MMA has limited room to deviate from the values its constituency expresses.

Services, *Mental Health: A Report of the Surgeon General*, Chapter 1: "Introduction and Themes/Mind and Body are Inseparable."

[21] According to Oaklawn officer Gregg Nussbaum, personal communication, Nov. 13, 2006.

Because many mental health facilities manage inpatient care to match closely what insurance will pay for, MMA tries to determine when inpatient care is no longer medically necessary. “Sometimes the person gets well at the point the benefits run out,” Garboden noted. “The ability to be well increases as the end of benefits approaches. For this reason, we will advocate for a transition to a lower level of care at the earliest opportunity. We don’t want the patient to be blowing through the lifetime limit any sooner than necessary. But what the person has to go home to must also be a concern, because the person who does not have an adequate support system will bounce right back to the hospital.”

Garboden suggested that the biggest obstacle to mental health parity is the need to remain competitive while providing a product that people want. “American people don’t value the treatment of mental health as much as they value treatment for physical health. There is only so far we can go in differing from this value and still remain competitive.” This point was driven home when MMA developed a new small employer product. MMA’s small group employer plans have a lifetime limit of $20,000 for mental health, half the lifetime limit of MMA’s individual health line. The company developed a product with more comprehensive mental health coverage (comparable to the individual plans), but it turned out that no employers wanted to pay for it. “Employers apparently do not value this benefit,” Garboden observed. “You don’t have many employees choosing an employer based on mental health benefits.”

A smaller obstacle to parity, according to Garboden, is the ambiguity that exists with mental health conditions about what constitutes progress. Protocols and measures of success are less clear; thus, what constitutes appropriate treatment is harder to determine than it is for other health conditions.

Christians committed to economic justice for persons with mental illness might reflect on the following questions:

MMA has made modest efforts toward retaining coverage for mental health, introducing coverage for self-inflicted injuries, and differentiating among categories of mental illness in underwriting. How can MMA's constituent denominations support the steps MMA has taken and encourage other such efforts?

Has MMA's decision to operate within the marketplace required it to compromise with ideals of justice for persons with mental illness? Has this decision helped or harmed the constituent denominations' ability to be stewards of God's resources for the benefit of persons with mental illness?

Does MMA's lack of parity in coverage contribute to the stigma of mental illness?

Rest Haven: a residential aftercare program

Rest Haven is a residential aftercare program run by the Amish community on the Oaklawn campus. The program serves Amish persons who need intensive mental health care but no longer need full hospitalization. They participate in day treatment led by "Dutch"-speaking Oaklawn staff and live in an environment sensitive to Amish culture. Since residents often come to Oaklawn from out of state, the residential facility provides a way for them to continue day treatment after they have been discharged from the hospital. Howard Miller, Rest Haven administrator, described the program to me and gave me a tour of their facility.[22]

Rest Haven has a close cooperative relationship with Oaklawn. Miller explained that for the Amish, receiving professional services from Oaklawn rather than help from someone who is Amish reduces some of the stigma of getting help for mental illness. Although Rest Haven makes shorter hospital stays possible, Nafziger noted that the Amish community encourages longer stays in day treatment than non-Amish payors will support, because they want to help

[22] Howard Miller, personal interview, October 23, 2006.

their members become healthy.[23] The Rest Haven program allows Amish persons with mental illness the benefit of culturally appropriate care for longer periods at a fraction of the cost of hospitalization.

Rest Haven's participation in systems outside the Amish community has led them to one readily visible departure from Amish tradition. When I commented on the bright electric lighting throughout the facility, Miller explained that telephone and electric services are a necessity because of safety codes. Because of the sharp cultural distinctions that set off the Amish community from its surrounding culture, Rest Haven is little affected by the market competition that impinges on MMA's choices. They are even less influenced by the changing tides of public funding that affect Oaklawn's administrative decisions since their funding is entirely private. This relative detachment allows Rest Haven to avoid issues of inequitable access to mental health care within the admittedly limited population they serve. A restriction to Amish participants is apparently imposed by cultural difference, particularly the "Dutch" language, rather than a decision to exclude others. Miller expressed that the program is potentially open to anyone who speaks the language.

The Amish community does not participate in insurance systems in our economy. This choice means that families must cooperate with each other and share decisions about health care. Congregations often assist families with costs. When medical bills are very large, congregations sometimes invite assistance from the wider Amish community. Through such arrangements, the Amish offer one model for the kind of community accountability Hal Loewen advocates.

Christians committed to economic justice who observe Rest Haven from outside the Amish community might reflect on the following questions:

What Amish values make a facility like Rest Haven possible?

[23] Nafziger, personal interview, October 25, 2006.

What obstacles stand in the way of other church groups following Rest Haven's pattern?

What possibilities inspired by Rest Haven might be compatible with a Mennonite or other denominational context?

Consumer perspectives

To supplement the perspectives of the administrators I interviewed, I offer a glimpse of two families, representative of the many diverse individuals with mental illness and their families who are consumers of MMA's and Oaklawn's services. These sketches represent specific families who shared with me details of their circumstances, although I have changed identifying data to respect privacy.[24]

Joanne

Joanne is a married woman in her mid 30s, a homemaker and mother of two young girls. The family is active in a Mennonite congregation, and they have MMA insurance. Joanne has had recurrent depression for ten years or more. Thoughts of suicide in recent months have been relieved by medication, but she still has bad days. Their MMA insurance covers medication, psychiatrist visits and some psychotherapy. In her therapy, she has been uncovering the impact of sexual abuse in her childhood.

Joanne's psychiatrist and therapist recommend that her medication will be most effective alongside ongoing psychotherapy. However, the allotted outpatient sessions covered by her MMA insurance have run out for the year. Therapy runs at least $100 per week for indefinite period. If Joanne and her husband decide to pay for more therapy, it will need to come out of what they can give to the church.

[24] Personal interviews, October 17, 2006.

Christians committed to economic justice for persons with mental illness might reflect on the following questions:

Is continuing weekly psychotherapy a luxury that Joanne should discontinue or an investment in the family's well-being?

Should long-term psychotherapy be available only to those with expendable income?

How can congregations support those in Joanne's circumstances to promote healing?

Bryan

Bryan is a single man in his 20s who enjoys playing the piano. He was diagnosed with schizophrenia four years ago during his second year of college, when he became a consumer of mental health services from Oaklawn. He needed to drop out of college due to his illness. His Oaklawn bills typically average $2,500 per month. Medications run an additional $1,000 per month. His father helped him negotiate the red tape so that he could qualify for Supplemental Security Income (SSI), Medicare, Medicaid, and food stamps.

Medicaid regulations limit him to no more than $1,500 in assets, which means he cannot own a car or a piano. SSI pays $650 per month for living expenses. With the help of Oaklawn's supported employment, he works about 15 hours/week at Target, earning $6.50 an hour. He would lose Medicaid if he worked much more than this, but without Medicaid, he could not pay his Oaklawn bills. His earnings reduce the food stamps he is eligible for, but it is worth it to him, because working raises his self-esteem.

Bryan's parents are retired and live in a spacious, well-kept home on a rural acreage. They give Bryan small gifts occasionally as permitted by Medicaid. Bryan's father keeps meticulous records of income, expenses, and gifts for Bryan to report to Social Security annually. Bryan's mother actively advocates with professionals at Oaklawn to ensure that

Bryan's treatment is appropriate. When I asked Bryan's father if it makes a difference that Oaklawn is a church-affiliated organization, he reflected both frustration and resignation to the system he works with: "No matter who you are working with, you [the parent] have to be the one who pushes the issues. They can't respond to the loved one as you do, because you are in closer touch. They don't do everything from compassion; they are doing it for money."

Christians committed to economic justice for persons with mental illness might reflect on the following questions:

Should having a serious mental illness require that a person live below the U.S. poverty line?

Are any options open to Bryan for moving further in the direction of supporting himself?

How do you set a value on the services Bryan's parents provide?

Conclusion

Economic justice pertaining to mental health care remains elusive in contemporary U.S. society. David Satcher's assertion made in 1999 holds true in 2006, "Formidable financial barriers block off needed mental health care from too many people."[25] Mennonite organizations committed to address mental health issues are hampered in their efforts to create justice for persons with mental illness by the values and systems of a culture still permeated with the stigma of mental illness. Yet Oaklawn's participation in the U.S. de facto mental health service system provides funding that enables the organization to offer mental health care to a large population from diverse backgrounds. MMA's participation in the U.S. health insurance system and market economy enables them to serve a constituency that desires such services and to offer broader than typical coverage for mental health. Less integrated with the surrounding culture, Amish leaders have found a way to serve their people with mental illness, despite their own culture's

[25] David Satcher, "Preface."

stigma against it. The courage of Oaklawn, MMA, and Rest Haven to chip away at the stubborn obstacle of stigma may draw inspiration from the remarkable courage of those who live with mental illness and the families and communities who support them. Such courage reminds us that hope and recovery are possible when care for mental illness is appropriate and sufficient.

Bibliography

James, Doris J. and Lauren E. Glaze. *Bureau of Justice Statistics Special Report: Mental Health of Prison and Jail Inmates.* Washington, D.C.: U.S. Department of Justice Office of Justice Programs, September 2006. Retrieved November 26, 2006. <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf>.

Leichty, Paul D. "Mennonite Advocacy for Persons with Disabilities." 195-205 in *Disability Advocacy among Religious Organizations: Histories and Reflections*. Ed. Albert A. Herzog. Binghamton, N.Y.: Haworth Pastoral Press, 2006. Also in *Journal of Religion, Disability, & Health* 10.1/2 (May 2006): 195-205.

Malina, Bruce J. and Richard L. Rohrbaugh. *Social-Science Commentary on the Synoptic Gospels.* Minneapolis: Fortress Press, 1992.

National Alliance on Mental Illness. *Grading the States 2006*. "Policy Recommendations." Arlington, Va.: National Alliance on Mental Illness, 2006. Retrieved November 25, 2006. <http://www.nami.org/Content/NavigationMenu/Grading_the_States/Recommendations/Policy_Recommendations.htm>.

National Mental Health Association. *It Is Time to Pass Comprehensive Health Insurance Parity!* Alexandria, Va.: National Mental Health Association, April 2005. Retrieved November 25, 2006. <http://www1.nmha.org/state/parity/index.cfm>.

National Resource and Training Center on Homelessness and Mental Illness, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. *Get the Facts.* "Question #3: Why are so many people with serious mental illness homeless?" Retrieved November 26, 2006. <http://www.nrchmi.samhsa.gov/facts/facts_question_3.asp>.

Shadow Voices: Finding Hope in Mental Illness. Prod. Burton Buller. Ed. Wayne Gehman. Video recording. Harrisonburg, Va.: Mennonite Media, 2005.

U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999. Retrieved November 26, 2006. <http://www.surgeongeneral.gov/library/mentalhealth/home.html>.

World Council of Churches. *A Church of All and for All—An Interim Statement.* Geneva: World Council of Churches, 2003. Retrieved November 26, 2006. <http://www2.wcc-coe.org/ccdocuments2003.nsf/index/plen-1.1-en.html>.