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MODELS FOR EFFECTIVE INNERCITY MINISTRY

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This article looks at Christian professionals in mental health in the context of the inner city. Many have contracted out of the inner city, forgetting the lower class, deprived, and underserved clientele, and preferring to serve the middle class. Jesus Christ taught an involvement with "all peoples." Five models for involvement with inner city clientele have been considered: 1) Community work — inner city clientele do not frequently respond to the conventional modes of treatment. Community work and crisis intervention seem more relevant. 2) Private practice in the inner city — Christians should consider a practice based on financial principles of many not-for-profit religious organizations. 3) Church based mental health programs — inner city churches can take an active role to meet mental health needs by providing financial assistance and space for clinics in the community. 4) Christians of minority status in mental health — biculturality is important and essential to bridge existing barriers between mental health clinics and the target minority clientele. 5) Christians in secular agencies — the name of Christ must be exposed in the services we deliver.

Addressing the focus of models for innercity ministry, we must first understand the term "innercity" to include a wide range of individuals living under a similar wide range of conditions: from the wealthy and highly educated to the impoverished and poorly educated. It is to this latter group of persons that I direct the focus of this article (p. 213). Gist and Fava (1974) write that "for many people the term 'innercity' conjures up a picture of decaying slums inhabited by disorganized and even dangerous people who live relatively close to the downtown areas' many commercial, cultural, and entertainment attractions." Gist and Fava give us a very good picture of how persons have frequently viewed the innercity: their apprehension and hesitation of involvement with it. This apprehension and hesitation by many is taken a number of steps further, where there is the response of wanting to render the innercity and, more specifically, its poverty as invisible or nonexistent. One author's feeling about this effort to make poverty invisible is that for many, poverty is grief and grief is intimate; grief, of course, being something that might better be avoided because of the often unpleasantness of it (Franco, 1973).

There is nothing wrong with this, however, since not everyone is suited for work involving grief. But, for those of us in the helping profession, grief is a large component of our work as we attempt to help with the different problems of the individuals we serve.

As one considers innercity ministry, one must realize the large group of people that we are talking about: persons whose needs often go unheeded. I refer to the ethnic and city groups such as Latinos, blacks, and migrant groups who carry on in urban enclaves the life of their home communities; the deprived individuals "whose handicaps of extreme poverty, emotional problems, and especially race prevent most of them from acquiring any but extremely poor housing in the worst areas of the city"; "the trapped and the downwardly mobile, for whom ownership of real estate, loss of social status, or happenstance have resulted in their inability to move from

crowded, deteriorated areas" (Gist & Fava, 1974, p. 274). The innercity is increasingly the home of these individuals (Elderedge, 1967).

Often, Christians define the innercity, its institutions, and more specifically its people as the "world," the world having connotations of immorality and sin. And, because we are to be "free from sin" (Romans 6:22) and to be born again believers seen as righteous before God through the life, death, and resurrection of His Son, Jesus Christ, such Christians sometimes think they should supposedly remain free from the world — free of our innercities. This is a common mistake and a misunderstanding of who we as Christians are to be, of how we are to live, but most importantly who we are to include in our life experience. It was a misunderstanding even in Paul's day. In Paul's first letter to the Corinthian church he spoke to this grave issue. He wrote, "In my previous letter I said, 'don't mix with the immoral;' I didn't mean, of course, that you were to have no contact at all with the immoral of this world, nor with any cheats or thieves or idolators — for that would mean going out of the world altogether" (Phillips, 1 Corinthians 5:9-10). Paul's instruction here is that we stay in the world to make an impact on the world for Christ. Jesus Christ Himself is our example and our model for outreach and work in the innercity. He preached involvement. He preached and demonstrated a compassion and concern for the suffering part of humanity (Boyd, 1969; Matthew 9). Christ's key to reaching and helping people in the innercity was involvement. Involvement meant meeting people "where they are" — their community. This is what Jesus Christ's involvement was all about. He healed, assisted, and met people's needs in their immediate community. He went to their "turf" if you will. This idea of "community work," therefore, is my first model and area of focus that I will consider when looking at the challenge of the innercity and the urgent need for workers in such a setting.

Prior to the community mental health movement in the sixties, the mental health needs of the innercity were to have been filled by conventional psychiatric theory and practice. Long term treatment and insight therapy were the order of the day. These psychiatric tendencies, however, neglected the client's environment when attempting to understand and treat mental health needs (Zusman, 1977). With a greater emphasis given to community mental health, local provision of care was seen in a more important light, where it became a must that services be available and accessible to everyone, regardless of geographic and economic barriers (Ozarin, 1977). Further, it was said that in order to really understand and treat families, it was important that treatment of clients be given where they live and work (Zusman, 1977). This provision of mental health services in the community, therefore, was different and new. With the move to meet clients "where they are," and to adequately fill their needs, new methods had to be devised. From this effort, crisis intervention and community outreach arose.

Jesus said, "Behold, I say to you, lift up your eyes, and look on the fields, that they are white for harvest" (John 6:35). I think this verse can relate and speak to the focus of community work. The word look in the Greek has the meaning of "to look closely" or rather "to visit." Looking at and examining closely the white fields of harvest makes it possible for us to know whom we are serving — we develop an intimate knowledge of the fields and more specifically, who the people are. To assess our clientele in this manner goes contrary to the training that many mental health professionals receive because it means leaving our offices and working in the community. Matza (1971) states that many individuals in the innercity are so "engulfed and demoralized by their situation that they are unable to effectively act against and overthrow existing arrangements or change them to their own advantage" (Matza, p. 139). So, if our clientele cannot come to us and are in need, we have no alternative but to make outreach to them in their community. For many mental health professionals, this is threatening. It means entering an unfamiliar and strange environment. If we turn the tables, however, we see that our inner-

city clientele experience the same fear and apprehension as we, but to a greater degree when coming to our offices outside of their community. Not only is there a fear of the unknown, but clients must consider the discrimination, the racism, the possible language barrier, and inappropriate services that await them. The risks are often greater for them.

Sergio Franco writes that there are such enormous built-in problems in the poverty of the innercity that it would be much easier for us if we did not try too hard to include them in our work. He adds, however, that the redemptive program left to us by Jesus Christ persuades us that we must include the innercity in our program and work; community outreach efforts must be offered them in such terms that will provide them the opportunity to accept our services (Franco, 1973).

James B. Taylor and Jerry Randolf in their book *Community Worker* provide a definition of community work that helps one to gain a better understanding of what I'm talking about here. They define community practice as a way of meeting individual, family, and group needs which are not usually met by the traditional agencies or clinics. Randolf and Taylor characterize community workers as persons who do much of their work with the poor and deprived. Part of the worker's time may be spent in helping workers from other agencies like public assistance, schools, the courts, etc., to cope with different client problems. Community workers are often found outside their offices. The practice of psychotherapy or other client-related treatment sometimes might have to be carried out across a kitchen table or in the client's living room. The worker stands ready to respond quickly to crisis and emergency. Coworkers might even include housewives, neighborhood aides, church officials, physicians, or maybe bartenders. Community workers are likely to get involved in community organization and agency planning. Finally, the work hours are often unusual and work settings sometimes strange (Taylor & Randolf, 1975).

My personal experience in community work has covered the gamut of the description given. Let me give a case in point. The identified client is Jerry. Jerry is 10 years old, the fifth of five siblings. He was referred for aggressive and impulsive behavior. I worked with Jerry and his family for 11 months. Specific complaints were that Jerry hit and kicked his teachers repeatedly; he had thrown furniture at peers; he verbally abused teachers and the principal; and he burglarized the school once. The family history is one of extreme emotional deprivation. Father is an alcoholic who was abandoned by his parents very early in his life. Jerry's parents separated permanently following a marital divorce one year ago. All five children live with Father. Father attempted suicide after his marital separation and was psychiatrically hospitalized. He presently continues to verbalize suicidal ideations.

When conventional therapy did not work with this family, community outreach was seen as necessary and appropriate. After seven months of futile community outreach, Jerry's father finally began to trust me as a worker and a helper. A trustful working relationship developed through accompanying he and Jerry to court, talking frequently with him at a neighborhood bar over coffee, and intervening for him as an example with the Internal Revenue Service regarding difficulties he had with them. At the end of nine months, Jerry's father finally saw the severity of Jerry's behavior. Although residential placement and child neglect charges were considered here, it was decided that the context of Jerry's hospitalization held the best possibility and opportunity to convince Father about his own personal emotional needs and that he should get help for them. Well, hospitalization for Jerry was finally carried out and Father along with his family were convened in treatment. Almost a year of outreach was necessary and seen as the only possible way to "hook" the family into treatment.

In Jerry's case, community outreach might be interpreted as an "expensive kind of treatment." True, it was very expensive. Much time was spent and invested in convening this family. But,

it must be seen that an extremely important inroad was constructed with this father, a relationship that often seemed impossible was built. Services so desperately needed by Jerry have been given and received by Jerry and his family. Initially, the only service was community outreach. There are many family units like Jerry's with extremely poor built-in inner resources who are unable to adequately manage their own lives. Traditionally, these families are forgotten or alienated because of insensitive "therapeutic approaches" that leave family needs unmet.

Community work is an important and essential model for work with innercity clientele. This model is actually an underlying base for the models that will follow in this article. The areas to be considered are: (a) private practice in the innercity, (b) church based community mental health programs in the community, (c) the need for Christians of minority group status in mental health, and (d) Christians in secular agencies.

Private Practice in the Innercity

Now who, in their right mind, would open a private practice in the innercity, servicing people whose poverty and related problems frequently make it totally impossible to pay for such services? The answer is that not many people in mental health think this way. I'm certain that the first question raised regarding employment in the innercity is: What is the return both personally and financially?

First, there are few rewards. Sometimes we cannot utilize our learning gained while in training. For the most part, a worker supplies modest help when people are in a bind. When the crisis is over, a worker sometimes finds that the clients didn't really want to change themselves or their situation in a drastic sense — they just wanted a little help, the kind that is here and now. About half of the time, a little help might clear up the bigger problems. No "dramatic" changes, of course. There are few exceptions though: People who are wanting profound change in their current struggle. One must not believe that this kind of success is frequent — it isn't (Taylor & Randolf, 1975). Second, a lot of energy is expended with clients "whose cup never seems to be filled to the brim" in spite of how much of your own cup one uses to fill theirs. Third, motivation is frequently low and time is frequently wasted because appointments are not kept. Ego strengths are often poor and shallow.

Granted, these are problems, but answers and techniques to approach these clients must be developed and utilized. First, a supportive staff is essential for re-energizing workers so as to avoid the "burn out syndrome." A staff who can pray for you and with you around problems that frequently arise in this kind of work is important. Second, charging fees on a sliding scale helps client motivation even if the range of fees is as low as $1.00. When individuals are forced to pay for something, their motivation for participation many times increases; they want something in return for their money paid. Their active involvement is essential, therefore, so that they get an adequate return for their money — "many people want their money's worth."

Third, and this does not discount what I have already said about community work, if we have our offices in the center of the community itself, eventual treatment at the office can be seen as a goal of treatment; the goal being that work begins in the client's home if he cannot make it to the office. As treatment progress is made, that is, as clients develop increased ego strengths, demands are placed on the clients to get them to come to the office. Increased demands on these clients will benefit their own developmental growth as well as safeguard against unnecessary and excessive energy that the worker need not expend in outreach. Although individual, group, or family therapy may not be possible initially, this kind of treatment has its place. This is sometimes possible immediately and at other times only after a lot of community work has been done.

The area of greatest interest, however, is the financial aspect of innercity private practice. Few of these practices exist. The financial base of a Christian practice can utilize principles used by many Christian organizations. I refer here to a "faith work which is dependent, under God, on

the faithfulness of the Lord's people; the church family, friends, and relatives" (Wycliffe). For many, this is seen as impossible. The frequent recourse taken is to forget the underserved people of the innercity. There is the common flight to the "more motivated middle-class clientele." One counseling program of a church I visited, in fact, has taken such a recourse. Located in the heart of a black ghetto, they direct their mental health services outside their immediate area to a people who can pay, who are "motivated," those whom they describe as more suitable and able to effectively use their treatment services.

Let us not contract out of the world (Bonhoeffer, 1973). Let us remain. To solicit funding and financial support for Christians in mental health is possible. I am reminded of John Perkins of Voice of Calvary in Mendenhall, Mississippi. He began his work with people right where they lived, developing church-community services relevant to the needs of the community. Support of VOC and financial support of private practice in the innercity by the church family is biblical. Christians in mental health who have the gospel of Christ are an important and necessary means with which to combat emotional, spiritual, and economic depravity confronting our innercities today.

Church-based Mental Health Programs in the Community

A model similar to the private practice model is the recent trend toward multipurpose health clinics. This is a national phenomena which also includes efforts by Christian churches in this direction. In Chicago there is Circle Church Community Center. Located in a black community, they acknowledge the importance given to geographic location which makes their center accessible to their clientele (Torrey, 1972). Along with a youth program, legal aid services, and health services, they provide a mental health program serving a particular innercity community. In addition to a sliding fee system, the director of the center solicits funds from individuals, businesses, and community groups, both secular and nonsecular groups sympathetic to the philosophy of the center.

As in the innercity private practice, the monetary return is not a lucrative one. The interesting and exciting occurrence here, however, is that various physicians, nurses, and mental health workers reach out to the center eager and wanting to serve. The key here, relates the director of the center, is the commitment and the desire to be used by the Lord for His service through a vehicle desperately needed by society.

As in the model of innercity private practice, comprehensive health clinics that include mental health services staffed by Christians are still in a pioneering stage. Christians in mental health again must approach the church as one who can serve as a partial financial base and provider to advocate and finance mental health services in the innercity. Janssen (1952) tells us in his book *These Cities Glorious* that God has called the church to a mighty task regarding the innercity. He writes that God,

> calls churches to labor on, to spend and be spent. There are those who are finding it an impossible task, humanly speaking. God is demanding what man can never achieve, as man. He is calling men to become the Body of Christ, that they be no longer men, but the hands and feet, the tongue and heart of his own Son (p. 150).

Written 26 years ago, Janssen's appeal continues to be relevant to today's church body as we consider meeting the mental health needs of the innercity.

The Need for Christians of Minority Group Status in Mental Health

Last year I visited a Christian youth ministry program whose focus is that of reaching delinquent adolescents in the innercity. By happenstance, I saw a group photograph of the regional staff — a large group. It surprised me to find only two or three nonwhite staff. My alarm stems from the realization that the large majority of their clientele is Chicano, black, and white. I wondered about the usual cultural gap that exists between whites and nonwhites. Where, I thought, are the "minority group representatives" who are often "specialists" in minority

group culture because of their background and experience, those who serve as a bridge between minority group clients and the program itself. This is often necessary if minority group clientele are to be served adequately and properly (Sue, 1977). It has been said that unless one has a knowledge of such biculturality, when seeing an individual, group, or family, it is usually not seen as worthwhile to ascertain their special blending of cultures which help to acquire a clear and realistic understanding of exactly who one is serving (Murillo, 1976). Nathan Murillo (1976) in his article about Mexican families writes that the cultural differences between the Mexican American and others can be viewed in terms of "differences in mental set or orientations, style of 'naturalness' in behavior" (p. 13). If we seek, encourage, and employ Christian mental health professionals who belong to the minority groups of our target clientele, we can better hope that existing cultural barriers between the client and the agency will be bridged. Let me hasten to add, however, that this does not discount the need for nonminority staff who are bicultural and bilingual when the need arises.

Literature tells us that minority group clientele receive inadequate mental health services. There is a general agreement that such inadequacy of services can be explained in the actual experiences that clients have in face-to-face interactions with the persons they encounter when they request mental health services (Sue, 1977). The clients' needs are not quite clearly understood, so inadequate treatment is received by them. In our work in the innercity, mental health professionals who are bicultural, and representative of the different minority groups we serve, are an important and essential ingredient if the desire is to meet innercity clients where they are. Clerical staff who are bicultural and who represent our clientele hold the same importance as mental health professionals with similar qualities.

Christians in Secular Agencies

For my final focus, I want to examine the role of the Christian worker employed in the secular agency. There are many of us who find ourselves here. It is a challenging position in which to be.

I think the question about our jobs that must be answered by every Christian in mental health is "How can I make an impact for Christ?" Some individuals answer this by stating that we have simply been hired as qualified workers to meet mental health needs — Christ has no place. It is sometimes continued that we were not hired as "Christian mental health workers," the issue being: What place does the gospel have in our work? How do we work it in? Do we?

I like what Detrich Bonhoeffer says about the visibility of the Christian church body. When talking about Christ's disciples, he states that having been called, "They could no longer remain in obscurity, for they were the light that must shine, the city set on the hill which must be seen" (Bonhoeffer, 1973, p. 278). So, Bonhoeffer's answer to the above question would be, I believe, that Christ must be exposed. He must be shared. To expose and share Christ is a challenge. We are to expose Christ even to an unwilling and unsupportive audience of colleagues who know not Christ, who demand that Christ does not have a place in our work. Christians in secular mental health must bring in the counsel of Christ and the reality of Christ to other professionals who attempt to make no place or room for Jesus Christ.

Again, Bonhoeffer states that we must engage in a frontal assault on the world — our agency, our colleagues, our clientele, living the life of our secular calling in order to show ourselves as strangers in the world. The antithesis between the world and who we are as Christians must be borne out in the world — in our work (Bonhoeffer, 1977). This is not to say that we hit our clients or whoever we meet with the gospel immediately. I think we all know this is not the issue. Timing is a key here. We must wait for the Holy Spirit to guide with regard to timing. Recently, I spoke to a brother in Christ about this concern. His answer to the question of where Christ fits in our work was simply put: "We learn through practice." Again, depending on the different needs of clients and the Holy Spirit's leading, the presentation of Christ and His Good

News has a perfect place and a special time.

One personal technique I have utilized for making an impact for Christ has been the linking of clientele to churches in the community. Frequently, my work is with emotionally deprived and empty individuals who essentially need reparenting — more than I can give them. Since I can give only limited support, energy, and time to such individuals, I try to tap the church as one who can help to supplement the assistance I give to my client with additional supports that he or she so desperately needs. I suggest a local church and recommend my clients attend the church service and get involved in the various programs of the church. Calling the church beforehand to prepare the church staff for my client's visitation and arrival is often necessary so that my clients feel welcome.

Conclusion

In conclusion, we have considered how Christians in mental health can play a role in meeting the challenge of the innercity. Five models were introduced as ways to confront and actually meet the needs of a group of people who are numerous in number but who are often invisible to us. Seemingly invisible, they are also seen in an unattractive light: Their inadequate educational preparation, low and frequently impoverished socioeconomic status, limited monetary resources, their language barriers, and general cultural conflicts contribute to make them so. These characteristics handicap and limit the services so badly needed by them. Literature informs us that mental health services they receive are essentially inadequate. Unless the Christian body rises to the occasion to meet the challenge of such needs as did Jesus Himself to meet our needs, such an inadequate delivery of services to the innercity will continue to prevail.

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RESPONSE TO PSYCHOLOGY AS URBAN MINISTRY PRESENTATIONS

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Christian mental health practitioners must recognize the problems in the cities without automatically equating "emotional sickness" to blacks. Such problems are also among poor whites and other minorities. Minority personnel are needed, however, to counteract the feelings of powerlessness and the dependency syndrome blacks experience when relating to whites. Minority workers may need liberation from their own materialistic concerns and actually live in the urban poverty areas, assisting in the task of building "affirmative independent institutions." Most important for effective urban work, racism must be actively tackled in the worker's own personality and in the structures of society.

Many excellent ideas have been presented in these articles. Instead of rehashing areas which I can affirm, I would prefer to highlight important themes and their implications, particularly expanding upon crucial elements of effective interventions that I do not believe are given enough attention, such as the influence of racism upon the maintenance of the problems in the center city and upon the effectiveness of mental health workers.

First of all, all of the authors have suggested that urban centers are needy places where stress, emotional disturbance, and a sense of powerlessness pervades. While this is true to some extent, I feel that most notions about urban life emphasize a pathological orientation and neglect the strengths of that life. Dr. Steele made this point, but I want to underscore it because it is too easy for folk, including Christians, to associate urban life with black people, and thus by extension, to "emotional sickness." Certainly, there are many, many urban minority families that are stable and happy, though poor, and whose children grow up healthy and successful. My husband and I live in one of the poorest areas of Chicago. Yet, we have neighbors who are solid and responsible, who have been pillars in the community they have lived in for many years.

With that disclaimer, it is important to realize that serious problems do exist in the cities, that poverty and oppression destroy. Such TV programs as "Good Times" distort when they depict the state of poverty as a constant hilarious scene. Etta Ladson, founder and president of the African Christian Teachers, Inc., said in a speech at the 1978 Convention of the National Black Evangelical Association:

> The destruction of the poor is still their poverty. Walk into the schools of the black poor. The child who can read and write competently is the exception. The schoolroom is the greatest single scene of slaughter in the nation. Ask the adolescents of the black poor to roll up their sleeves. In New York City alone, more than 33,000 blacks are drug addicts. Visit the prisons of the nation and see who occupies the cells. . . . Eighty-six percent of the prison population are the black poor, predominantly minority males under 30 years of age. The culture's attempt to make poverty seem to be a natural and right lifestyle for some is satanic. . . . God loves the poor — not poverty — and not because they are poor. He loves them protectively against the strong who oppress them and exploit their weakness.

The tendency to think black when thinking urban is indicative of another basic flaw in urban strategy because usually little or no attention is given to the needs of the white poor in the cities. Particularly is this true of the Appalachian white, a very neglected urban dweller. Also neglected are the needs of such groups as Latinos and, to a lesser extent, Asiatics who also suffer from poverty and oppression. The Humboldt Park racial flare-up in Chicago in 1977 demonstrated how