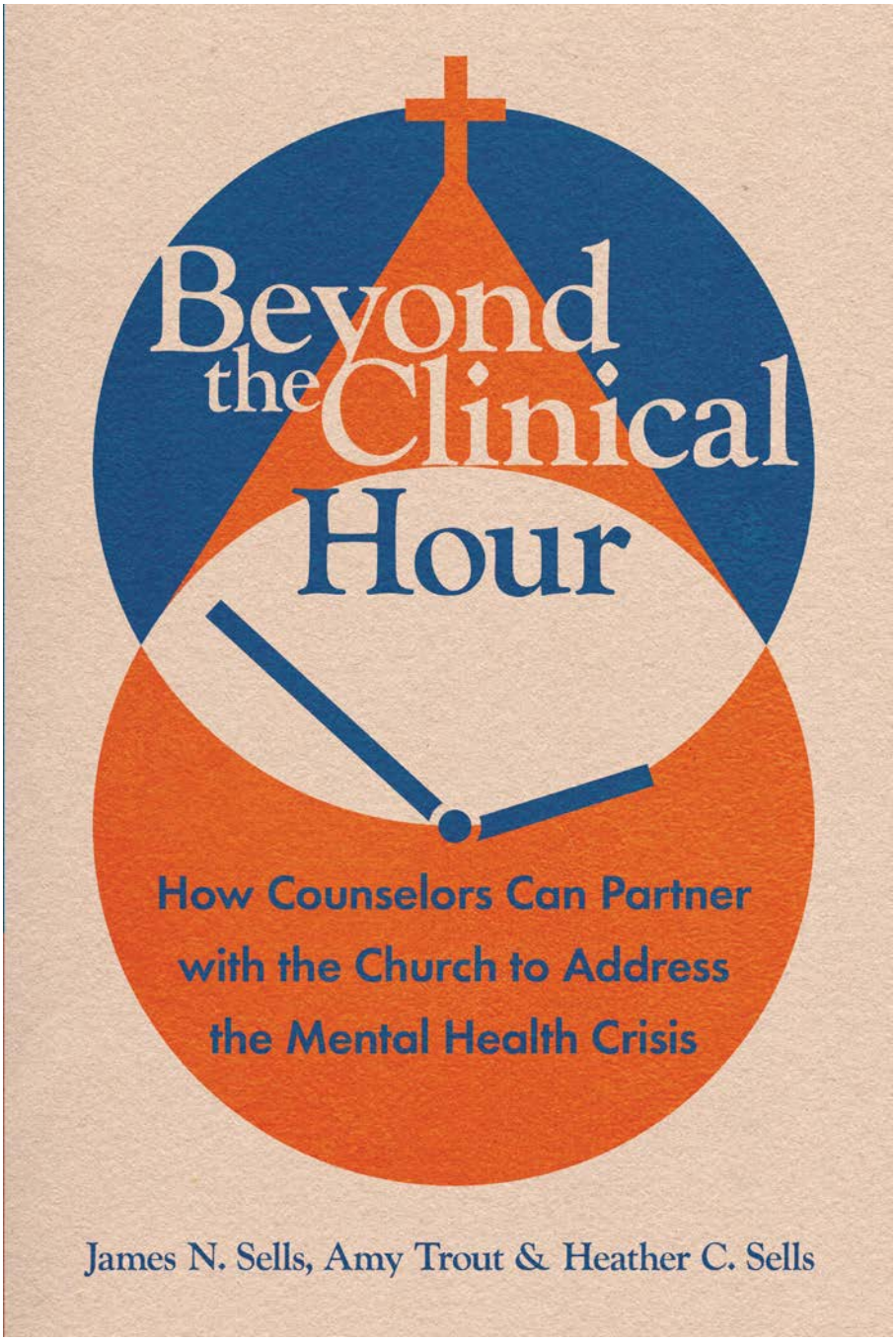

ivp | InterVarsity Press
ivpress.com

Published by InterVarsity Press, Downers Grove, IL.
www.ivpress.com.

1:00

Synthesis of Care

The Confluence of Culture, Church, and Counseling

We herd sheep, we drive cattle, we lead people.
Lead me, follow me, or get out of my way.

George S. Patton

People hurt and the church can help. Nothing new here. The church has offered "benevolent programs"—care and share funds, food pantries, and housing assistance—for centuries. Anyone can see that churches do "nice" things for people. But the idea that the church can play a major role in the delivery of mental health in the United States and worldwide is not something many have considered. We believe governments, the mental health profession, insurance providers, and graduate programs should collaborate with religious institutions to address the need at levels impossible to attain through separate efforts.

The church should play a prominent role in providing mental health care for several reasons. First, the need is growing at an alarming pace. Second, the cost to treat those in need will bankrupt the health care system. Third, even if everyone had the funds to pay for the service, the number of clinicians required to treat those in need is beyond the scope of our educational system. These are the conditions facing us in the twenty-first century. In the current system

of mental health care, funded by government support, private medical insurance, and self-payment, there is no mathematical regression equation in which the problem is adequately addressed with the funds and the human resources available. None.

This chapter will examine factors in the current cultural context that could prevent systemic change regardless of the need. The main problem we'll consider here is leadership. Addressing the mental health care demand will require collaboration of a plurality of groups, each very powerful in overlapping spheres. In an age where entities neither trust nor collaborate, they must learn to work together for the greater good.

Searching for Christian Community

Jess met Jesus in high school, sitting on a mountainside perch at a Christian camp in Colorado. "I just felt Jesus there," she explains emphatically. A friend told her she'd been praying for Jess for a long time.

Soon after she battled a life-threatening disease that led to surgery. For months, she found herself very lethargic but attributed it to the recovery process.

In her freshman year of college, the struggle to meet normal life demands began in earnest. She started missing classes and lying in bed for hours. A roommate suggested she might have depression and soon after she received her diagnosis: depression with mixed features. Jess didn't even know what the diagnosis meant, but she remembers ripping up her medical paperwork and rejecting what she had just been told.

Despite her diagnosis, Jess devoted herself to her studies and joined the worship team of her on-campus ministry organization, rehearsing and leading music weekly. Still, she quickly found her depression getting in the way and, equally as difficult, a Christian community that misunderstood her.

"I was very Pentecostal in college. They thought I was just very in tune with the Holy Spirit. There'd be strings of nights when I didn't

sleep at all because I was having a manic episode," she said. During those sleepless nights, she would often turn to her music and song writing. In turn, her community praised her for her talents.

When she would confess her deep despair over her mental health struggles, she found Christian leaders minimizing it. "Adults kind of wrote it off, especially the older they were." They said, "You're fine. You just need more exercise or whatever." And she found her own friends keeping their distance, not understanding what she was experiencing.

Some of those friends later apologized to Jess for not understanding, a move she warmly received. For several years she joined a women's Bible study group and found herself supported and accountable to others. But still, she noticed she kept downplaying her personal battles and asking instead for prayer for her mom's cancer. To her, a mental health prayer request felt scandalous.

Today, Jess has put dreams she once had of owning a business on hold, possibly permanently. In her thirties now, she lives with her sister and is searching for work that will give her financial independence. She is also searching for a Christian community that can understand her. She feels support from her friends but is not free to express how deeply she struggles.

Defining the Problem

To meet the mental health demand within the United States using our current model of care, we would need to train hundreds of thousands more clinicians to serve *millions* more who suffer from the full spectrum of mental health disorders at a cost of *billions* of dollars per year.

To use a metaphor, let's say that the number of cars on the already congested roads and freeways was increasing in number at a rate of 20 percent per year. In just a few years we would double the number of cars on the road. One solution might be to build more roads. But no matter how fast roads are built, the number of cars keeps increasing. Imagine a major freeway being thirty lanes wide yet still congested.

There is no more money to design and build more roads. At some point local leaders begin to see that the traffic doesn't seem to be solved with more roads. This illustration suggests two different kinds of problems: the traffic and the political will to imagine and implement a different system.

When it comes to the church, Ed Stetzer identified the problem as a training and guidance deficiency: "Pastors need more guidance and preparation for dealing with the mental health crisis. . . . Pastors and the police are often the first responders in mental health crises. Those crises give the church the opportunity to be the church—to demonstrate the love of God to families and fellow believers in their time of need."[1] The church has the mental health crisis at its doorstep, with a figurative army of people who wish to lend a supportive ear, a soothing voice, and a wise word. In contrast, the prevailing belief in North America over the last fifty years has been that mental health concerns should be addressed by the professionals and that mental health care should be funded by third-party payers such as insurance companies. For example, it is commonly recommended that when people experience depression or anxiety, they should work with therapists, counselors, psychologists, psychiatrists, or social workers to address those issues.

As trained psychologists and counseling professors, we believe the role of mental health professionals is more important today than ever. Trained clinicians capable of understanding mental health science are in great demand. But rather than advocate for more resources directed toward the professional caregivers, we are calling for clinicians to work within the community context. The number of people looking for therapy is too great for the cadre of existing professionals. Instead, the clinician must become an educator, supervisor, consultant, and

[1]Ed Stetzer, "How to Assess the Mental and Relational Health Needs in Your Church," in *The Struggle Is Real: How to Care for Mental and Relational Health Needs in the Church*, ed. Tim Clinton and Jared Pingleton (Bloomington, IN: WestBow Press, 2017), 2.

adviser. The profession must partner with the community to meet the need. As the need for mental health care grows, the nature and delivery of care must grow as well.

Figure 1 illustrates the current model of mental health care. The large rectangle in the lower portion of the diagram contains three components of need: Serious Mental Illness, Any Mental Illness, and Personal/Relational Need. The first two levels of need are diagnosable conditions identified in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), the manual of mental

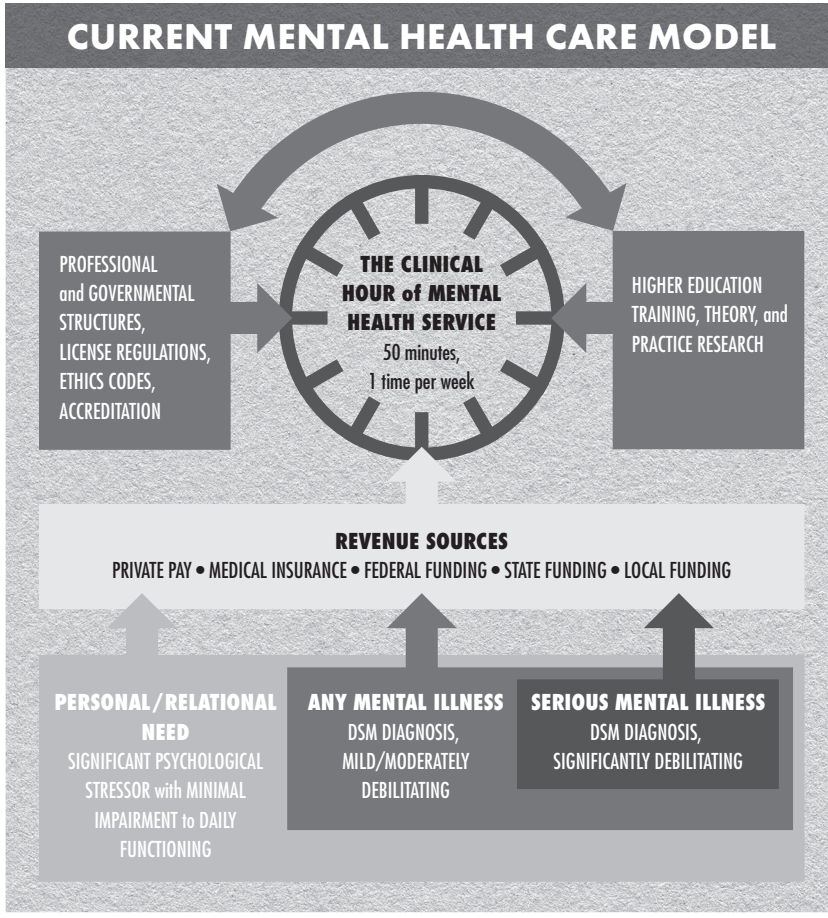

Figure 1. The current mental health care model

health disorders published by the American Psychiatric Association. There are about 157 distinct conditions described in the 2022 edition. These can be acute (think intensity) and chronic (think long-lasting). Or they can be mild/modest and fleeting. But there are significant impairments in life functioning. The third and largest component in the block, Personal/Relational Need, represents significant painful issues or experiences that are challenging and require attention, but they do not impede a person's capacity for daily functioning. These people get up, go to work, and care for others, but they remain in pain.

The smallest rectangle in the lower block, Serious Mental Illness, represents the most acute need. This includes people who are diagnosed with life-debilitating mental illnesses—schizophrenia, dementia, and in some cases, substance-dependence disorders, bipolar I, and major depressive disorders. These diseases prevent a person from engaging in normal and common life experiences. Treatment likely includes medication, psychotherapy, and at times, hospitalization.

The second level of mental illness, incorporating a larger portion of the population, is Any Mental Illness, identified in the middle of the figure. This represents any DSM-5 diagnosable conditions that are serious and impede life functioning. These would include most mood disorders, anxiety disorders, and disorders in childhood, such as the range of attention deficit disorders.

Finally, the largest block represents the Personal/Relational Needs. Most everyone at one time or another experiences life stress, personal adjustments, family crisis, and marital/relational conflict. They frequently seek intervention and support from professional mental health providers. There is not a medical condition per se, but the issues are significant, and good counsel is a valued intervention, for example when individuals experience change, such as a career transition; grief, as in the loss of a loved one; or marital/family tensions.

Now move to the middle tier in the model: revenue sources. This is how the services identified in the lower portion are funded.

Regardless of the nature of the need, the intervention is usually delivered through a mechanism such as private health insurance; public mental health care such as Medicaid; state/community-funded mental health services, which are often paid as block grants to not-for-profit agencies; and self-payment. Most every need, from schizophrenia to adjustment to the demands of life in a new community, is funded through some source within the mental health care economic model. In almost all cases, the clinician is a master's or doctoral-level mental health professional, compensated through one of these means.

The top tier in the model, the circle, is the intervention structure, the clinical hour. While there are many types of interventions, such as hospitalization, group therapy, animal-assisted therapies, and so on, most that are funded by the mental health economic system using the clinical hour. It is usually a fifty-minute session with a licensed mental health care professional, be it a counselor, social worker, marriage and family therapist, or psychologist.

The rectangle to the right of the intervention structure represents the institutions of higher education. They train clinicians and conduct research on the clinical effectiveness of the interventions they develop and prepare students to deliver. The rectangle to the left of the intervention structure represents the professional organizations and state oversight boards. These institutions set the standards for training, determine and enforce ethical parameters, and create licensing laws to operate as a mental health professional within the agency's jurisdiction.

The sheer size, scope, and prevalence of people in need has created the demand for a massive intervention system. The funding challenge to meet it is so large that it must somehow be "managed." This term has become synonymous with the control of costs, and the most effective way to control costs is to restrict practice, and the accessibility or quality of care. The necessity for cost controls and limitations of service dominates the conversation regarding service provision. The

professional literature reflects opinions regarding the intrusion of managing the financial strains between clinicians and clients. Tjeltveit writes of this issue:

> A science-informed, collaborative relationship for the purpose of improving the well-being of a client can be seen as nothing but a business relationship involving the contractual exchange of money among several parties, management by a third party, and a commodity: psychotherapy. That change in language illustrates a process I call the "commodification" of therapy, an ugly word befitting an ugly transformation. . . . Likewise, counseling psychologists can (and should) treat their clients as persons of worth even if managed care accountants think of them only as consumers whose use of an expensive health care commodity must be managed.[2]

Both the church and the counseling profession typically view the relationship with those who are suffering with the highest regard. Both respect the idea that those who seek care are people in pain. The church and those in Christian mental health care even go so far as to inextricably link the idea of human care to God. Individuals, marriages, and families are tied tightly to the center of our existence as beings created in the *imago Dei*. Therefore, this issue of too many people in need at a cost out of reach for many because of the absence of suitable providers is much more serious than an excessively long grocery story line or a supply chain shortage that delays a birthday gift for a friend. Mental health provision carries a moral weight that should prompt us to create innovative solutions.

Yet instead, we easily go to causation and blame. We ask, "How did we get here? Why is this the case? What is the cause for the pervasive decline in care and the exacerbation of need?" We turn to political ideologies and theological or philosophical commitments. Depending on who you're talking to, the answers to these questions might include:

[2]Alan C. Tjeltveit, "There Is More to Ethics Than Codes of Professional Ethics: Social Ethics, Theoretical Ethics, and Managed Care," *The Counseling Psychologist* 28, no. 2 (2000): 245.

- the breakdown of the family
- economic inequality
- the removal of God and our Christian origins from our national dialogue
- personal failings and lack of discipline
- absent fathers
- institutional racism
- the media
- sin
- Republicans
- Democrats
- _____ (any number of other reasons)

And so, we fight. It's a conflict that Christian thought leader and author Rodney Clapp identified decades ago and summarized as though he could see it today:

> The postmodern discovery is that the great guiding light of reason, when seen through the prism of different cultures, diffracts and divides into competing lights. The underlying faith and hope of modernity have been shattered so that we truly live in times of "religious crisis." That is, there is not widespread agreement on what is our ultimate good, the common end or goal of our society. And we now know that reason cannot stand above and apart from the fray to provide a common good. Consequently, we fight endlessly over abortion, over homosexuality, over what genuine justice is, over the meaning of family itself.[3]

Seeking consensus on the root causes is vital before we move toward finding a solution, as emphasized by Clapp. Many of us, perhaps including yourself, have witnessed the perpetual disputes that arise when this step is bypassed. To facilitate genuine change, we

[3]Rodney Clapp, *Families at the Crossroads: Beyond Tradition & Modern Options* (Downers Grove, IL: InterVarsity Press, 1993), 23.

must prioritize dialogue over dominance. It's crucial to enlighten rather than impose, to propose rather than mandate. We should extend an invitation rather than exert pressure. Above all, we need to exemplify the potential of harmonious collaboration between faith communities and professional mental health practitioners in nurturing holistic human care.

We can create a solution for an expanding problem. But we can't change the culture by remaining in a culture war mentality.

An Alternative Plan of Action

In 1956 Ray Kroc was operating a couple of small hamburger stands when he was confronted with a life-changing idea—that he wasn't in the hamburger business. He was in the real estate business. That idea led to the creation of the McDonald's empire. Kroc realized that there was something bigger than hamburgers in the franchise business: land. In similar ways, the focus of this book is bigger than mental health care delivery. It's about culture—engaging, changing, and ultimately, creating a different culture.

For many people, culture is the battlefield where ideas are contested, and the side that generates maximum force controls the decision-making. The church has engaged in this battle, and over time its identity has become increasingly political. This is not to say that the church should not be involved in the political process. Rather, it is to suggest that when we consider how mental health can be reconstructed to include the church as an essential copartner, our battlefield mentality will likely interfere with, rather than contribute to, our success—unless we conduct ourselves differently.

Several Christian thinkers offer us a helpful framework for understanding culture. Rather than seeing it as the opposition with whom we will do battle, Paul Gould suggests that the church is to "*resurrect relevance* by showing that Christianity offers plausible answers to universal human longings. And she works to *resurrect hope,* creating new

cultural goods and rhythms and practices that reflect the truth, beauty, and goodness of Christianity."[4] Some have challenged us to think of culture and power as part of how we live faithfully to our calling. Culture is the rules, expectations, rubrics, or structures we use to create something else. Andy Crouch writes, "*Culture is what we make of the world.* Culture is, first, the name of our relentless, restless human effort to take the world as it's given to us and make something else."[5]

Couples, families, clans, and ethnic groups form culture to define the rules of life together. Culture is created in every human context. We can say, "Where two or three are gathered, there is culture." Culture provides the unwritten rules that define and clarify how one navigates life in the classroom, the sandbox, the cafeteria, the office, and even the bus. Google's culture is characterized by Ping-Pong tables, emphasizing a high value on creativity. In decades past, IBM Blue was a culture—businesslike, responsible, and powerful. Each church, each athletic team, and each home develop a unique culture.

Mental health professions also have a culture. Those cultures consist of standards and expectations by and for those who are competent to address mental health issues. This culture is evident in professional organizations, ethics codes, and laws pertaining to licensure, billing, and practice. Schools participate in this culture by creating curricula that define how the next generation of culture bearers is educated. The publishing industry participates in the culture as it creates products for sufferers and caregivers to use. These structures were created to define and navigate our mental health culture. When an issue emerges, individuals engage the culture to address it. They

[4]Paul M. Gould, *Cultural Apologetics: Renewing the Christian Voice, Conscience, and Imagination in a Disenchanted World* (Grand Rapids, MI: Zondervan Academic, 2019), 24, emphasis added. Gould credits the term "resurrecting relevance" to S. Michael Craven, *Uncompromised Faith: Overcoming Our Culturalized Christianity* (Colorado Springs, CO: NavPress, 2009).

[5]Andy Crouch, *Culture Making: Recovering Our Creative Calling* (Downers Grove, IL: InterVarsity Press, 2013), 23, emphasis added.

make an appointment with a counselor or listen to a podcast by a psychologist. Each of these are cultural tools designed to address a problem.

By many measures, our culture of mental health care treatment created by clinicians and insurance companies, and supported by government agencies has been extremely effective. Treatments promote change, medications work, and research continues to advance our knowledge. The culture and the professionals who have created and work within it are extremely effective.

Still, there is just too much work to do. Recall the thesis of the chapter: to meet the mental health demand within the United States using our current models of care, we need to train hundreds of thousands more clinicians to serve millions more who suffer from the full spectrum of mental health disorders at a cost of billions of dollars per year.

The culture that we have created around a fifty-minute session with a licensed professional possessing a doctoral or master's degree and thousands of hours of supervised experience is time intensive and extremely expensive. This culture permits each clinician to see about two hundred different clients per year. It is common for the therapist to see those clients for about ten sessions. Seeing 200 people about ten times is about 2,000 hours per year, which is typical for a therapist's annual workload. But the data suggests that there are some twenty million people each year who do not receive the mental health services needed. With these numbers, the problem is obvious. Graduate programs can't train the number of additional therapists needed for those people. Insurance companies and federal and state social service providers cannot pay for that number of sessions. Our resources are swamped. In our current system, we are indeed stuck.

Friendship with Those on a Similar Path

Across the country there's a burgeoning peer movement that's connecting churches with the people in their community who are suffering from mental illness, along with their families and loved ones.

Pastor Brad Hoefs, the founder of Fresh Hope for Mental Health, is convinced that the answer to living with long-term illness is the friendship of those on a similar path.

"A peer can make all the difference talking to another peer," he said. "Talking about what works for them, what helped them and being there for them can be a major factor in that person being better."

Hoefs founded Fresh Hope in 2009 after his own bipolar relapse and inability to find a support group that offered him hope around his diagnosis. Instead, he found himself becoming more discouraged about the prospects for living well with his disease.

"You start to become who you hang out with. You learn how to be chronically ill, let the diseased part of your brain become your identity," he said. "Intuitively, I knew that wasn't good."

Fresh Hope has since grown to include more than eighty support groups in the United States and internationally. It trains and certifies group facilitators who receive recommendations from their pastor. Family members are also welcome. The meetings are free, and Fresh Hope offers separate groups for teens and those dealing with specific issues, such as losing a loved one to suicide.

Lucy is a Fresh Hope leader who has trained facilitators in the Latino community. She acknowledges the tough cultural taboo that still exists around mental health.

"It's like—don't air your dirty laundry," she explains. Often, that means minimizing symptoms or seeking out a general practitioner instead of a psychiatrist or therapist. Finances are often another hurdle as is the fear of deportation in the United States.

For Lucy, Fresh Hope has made all the difference, giving her a vision for a full, rich life living with her diagnosis.

That vision has come from watching her Fresh Hope peers in an online group enjoy their lives and live them with purpose.

"The first thing that struck me," she said, "was there was this group of people—all of them had a mental health diagnosis and all of them were thriving."

Building a New Mental Health Culture: Working with Resistance

If cultures are created to respond to need, then they can be formed with intention. But when new needs arise that require a culture change, there is resistance from those who have established and who benefit from the current cultural practices. Changing a culture requires strong leadership.

The adage from American folklore is that if you build a better mousetrap, the world will beat a path to your door. The creator of that adage is not referring to having a rodent problem and the need for an effective remedy. Rather, they're saying if you build tools that meet the needs of a culture better than the tools that have been in use, those in need will find you. Good ideas form new cultures. The movie version of this concept is "If you build it, they will come."[6]

This brings us back to Andy Crouch and his concept of culture making. According to Crouch, "The only way to change culture is to create more of it."[7] When culture changes, it is because some new tangible tool or system becomes available to a wide enough public that it begins to reshape their world. For cultural change to happen, something new displaces, to some extent, existing culture. "So if we seek to change culture, we will have to create something new, something that will persuade our neighbors to set aside some existing set of cultural goods for a new proposal."[8]

[6]Phil Alden Robinson, dir., *Field of Dreams,* Universal Pictures, 1989.
[7]Crouch, *Culture Making*, 67.
[8]Crouch, *Culture Making*, 67.

However, before we can seek to change a culture, we must first look at some common mistakes people—Christians, in particular—tend to make when attempting to effect change. Crouch identifies four inadequate responses to cultural needs that keep us stagnant and stifled in the face of problems.

1. *Condemning culture*. This is an "everyone is talking about the weather, no one is doing anything about it" argument. Churches see widespread disarray and continuing decline in key wellness and spirituality indicators, and view the current solutions as inadequate. They then create alternative programs geared toward serving their own congregations and have minimal impact on the culture outside the church.

Crouch writes,

> If all we do is condemn—especially if we mostly just talk among ourselves, mutually agreeing on how bad things are becoming—we are very unlikely indeed to have any cultural effect, because human nature abhors a cultural vacuum. It is the very rare human being who will give up on some set of cultural goods just because someone condemns them. They need something better, or these current set of cultural goods will have to do, as deficient as they may be.[9]

2. *Critiquing culture*. Crouch's second problematic response concerns the intellectualization of any cultural phenomenon. This is most evident by the media talking heads who are paid to entertain their audiences by talking about how actions or measures taken in a given situation are insufficient. In Crouch's words, "The best critic can change the framework in which creators do their work—setting the standard against which future creations are measured. But such analysis has lasting influence only when someone creates something new in the public realm."[10]

3. *Copying culture*. Copying culture occurs when people mimic large portions of a culture but alter certain subpoints to make it more

[9]Crouch, *Culture Making,* 68.
[10]Crouch, *Culture Making,* 69.

acceptable to a subgroup. One example is church-sponsored Halloween events where candy is distributed out of the trunks of cars or trucks in the church parking lot. They have copied aspects of Halloween celebration, but it's removed from the neighborhood context where people can engage with other children and parents as they walk the dusk-lit streets in costume. When it comes to mental health, churches can create mental health ministries for themselves, but if they stop with self-service they deny the Great Commission impact of Christian calling (Mt 28:16-20). As Crouch notes, "When we copy culture within our own private enclaves, the culture at large remains unchanged."[11]

4. *Consuming culture.* The church has historically aimed to influence societal shifts by endorsing boycotts, often opting out of one cultural facet in favor of another. Think back to the times when bowling alleys, movie theaters, and nightclubs were in the crosshairs. Perhaps our most notable attempt at this strategy was during the temperance movement. However, upon reflection, even that effort had its flaws and shortcomings. Effecting change through this method hinges on the collective decisions of large groups of people, a task easier said than done. Also, as Crouch writes, "It should not be too surprising that consumption is an ineffective way to bring cultural change, because consumption is completely dependent on the existence of cultural goods to consume in the first place."[12]

Creating Culture

Crouch believes that culture is created and re-created as a result of forming products to meet a new need. The new product and the new culture around that product address the need better than anything that currently exists. Creative culture making requires maturity—reflecting the capacity to engage the culture, to steward it, and to exercise the discipline for transformation.

[11]Crouch, *Culture Making,* 69.
[12]Crouch, *Culture Making,* 72.

If there is a constructive way forward for Christians, it will require us to recover these two biblical postures of cultivation and creation. And that recovery will involve revisiting the biblical story itself, where we discover that God is more intimately and eternally concerned with culture than we have yet come to believe.[13]

In the cultivating and creating of culture, humility must abound. "Cultural goods cannot be imposed—they can only be *proposed*. How the public responds is never fully in anyone's grasp—and that is as true for parents serving chili as for presidents declaring war."[14] Society doesn't "need" us to save it from itself. We run the risk of being cast as preachy holier-than-thous who seek to make life decisions for others. Guilt is a horrible motivator toward change. Rather, mental health professionals are cultivators of the human care culture. We implement sound, empirically grounded techniques toward human care. And we are creators—able to imagine ways to deliver the service to critical masses of people who need it.

The mental health need is the call to creative solution making, a proposal that the existing structures of the profession collaborate with the existing structures of the church to address suffering. One group has the resources of knowledge. The other group has the resources of mission. We submit that the Christian counselor, psychologist, therapist, or social worker is the link between these two groups.

Crouch concludes:

> We enter the work of cultural creativity not as a people who desperately need to strategize our way into cultural relevance, but as participants in a story of new creation that comes just when our power seems to have been extinguished. Culture making becomes not just the product of clever cultural strategy or the natural byproduct of inherited privilege, but the astonished and grateful response of people who have been rescued from the worst that culture and nature can do.[15]

[13]Crouch, *Culture Making,* 98.
[14]Crouch, *Culture Making,* 98.
[15]Crouch, *Culture Making*, 227.

When It's All Said and Done

Here is where we are: our mental health needs are growing at an exponential rate. We see evidence of a new culture emerging from within the church to address it. The professional mental health culture should support innovative expressions of mental health ministry because the church can contribute in ways the professional culture cannot due to the size and expense of current models of care. We believe that current and emerging Christian mental health professionals are key to the future of care because of their common commitment to both church and clinic.

The partnership between church and clinic is symbiotic, benefiting both through mutual goals. The church has resources, both human and structural, to address the mental health need in a way that the profession cannot. But the church lacks the technical expertise to plan, implement, manage, assess, and improve its programs and services in mental health ministry. The Christian counselor, the community of thousands of trained caregivers who share in the mission of Jesus to a needy world, stand in both the community of mental health professionals and the community of faith. In order for the church to "retool" itself, however, the community of Christian mental health professionals must be prepared to lead.

Figure 2 is a visual depiction of how the church and the mental health clinic could collaborate in delivering care. The model is like the one presented earlier in this chapter. The lower third is unchanged. There remain three levels of mental health need: Serious Mental Illness, Any Mental Illness, and Personal/Relational Need.

The middle third, the funding source, suggests that there are two emerging sources of funding for care. The middle rectangle remains unchanged, the continued use of health insurance to fund professional clinical care. Around it is a gray rectangle that represents a ministry-funded endeavor for human care. Much of the workforce might be volunteers, but it will have a strong presence of mental health professionals who can advise, consult, train, evaluate, and supervise the ministry.

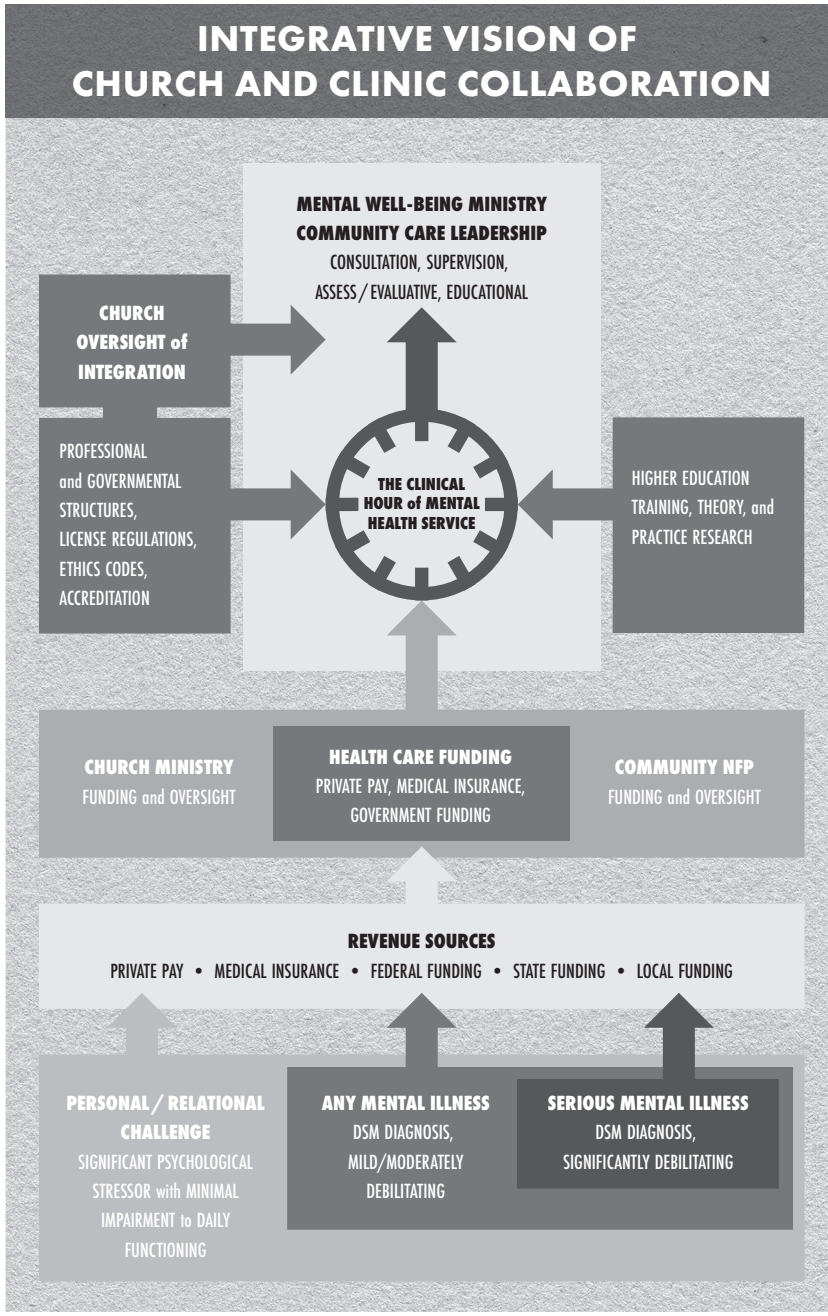

Figure 2. The integrative vision of church and clinic collaboration

Finally, the top third of the model contains a smaller "clinical hour" circle. This represents a reduction in the reliance of the mental health profession to deliver services to all the mental health needs. Emerging around the mental health professional is the larger box. The model suggests that mental health care can be conducted in a clinic-ministry collaboration. Outside entities such as higher education, professional societies, and licensing boards exist and contribute as they have historically. The uniqueness is that the church, the profession, and the Christian mental health provider recognize the new culture and create appropriate rules, oversights, ethical provisions, and services that can deliver the interventions to the population, all while maintaining the church's and clinic's unique identities.

Conclusion: Change, Resistance, and Vision

"The only constant in life is change,"[16] Heraclitus said. It seems that there is one thing that remains, resistance to movement or change. This chapter is a call to leadership during resistance. Need forms the environment for innovation. In the next chapter we will define the need by presenting the data demonstrating an advancing mental health crisis worldwide. We see evidence of need response emerging in churches everywhere. The grassroots solutions are preemptive changes in response to the demands occurring in every church community. But addressing the need, which affects millions, with responses that assist dozens is insufficient. The change needed is institutional. The church, meaning the culture created by those with a shared "kingdom vision," is in a unique position, carries a common mission, and possesses the physical and human resources to contribute to this change.

Leaders are needed to change the existing mental health institutions into structures capable of addressing the depth, width, and height of human need. Christian mental health professionals, professors, and

[16] As quoted by Plato in *Cratylus* 401d.

university administrators who prepare the next generation of Christian clinicians and researchers, and students who respond to the call to service within the mental health vocation and ministry are the ones to lead this change. Toward this end, Andy Crouch writes:

> Perhaps a new generation of leaders will arise who want to build for posterity, to plant seeds that will take generations to bear fruit, to nurture different forms of culture that will be seen as blessings by our children's children. If we are serious about flourishing, across space and through time, we will be serious about institutions.[17]

Questions for Reflection

1. In what ways do you see evidence within your church of attempts to condemn, critique, copy, or consume culture?
2. In the sidebar about Jess, she shared believing that her story was bleak, that her mental health condition would be a lifelong struggle, and that there would be no place in the church for her to experience acceptance and ministry fulfillment. What would be Jess's experience if she were to attend your church?
3. Consider the problem we have identified: to meet the mental health demand within the United States using our current models of care, we need to train hundreds of thousands more clinicians to serve millions more who suffer from the full spectrum of mental health disorders at a cost of billions of dollars per year.

   If you had all power and all authority to fix this issue, in the church or within the current mental health system, what would you do?
4. Consider the example of Fresh Hope. How is the traditional mental health model similar to or different from a faithful and true friend?

[17] Andy Crouch, *Playing God: Redeeming the Gift of Power* (Downers Grove, IL: InterVarsity Press, 2013), 188.