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The gatekeepers: Clergy involvement in referrals and collaboration with mental health and substance abuse professionals

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The Gatekeepers: Involvement of Christian Clergy in Referrals and Collaboration with Christian Social Workers and Other Helping Professionals

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Christian clergy play an important role in identifying individuals with mental health (MH) and substance abuse (SA) disorders and providing education, support, and referrals to needed services. In this study, researchers conducted an online survey with over 200 Christian clergy from 50+ denominations to explore their perceptions of MH and SA disorders and willingness to collaborate and refer church members to professional service providers. Findings showed that more than half of all clergy encountered persons with MH or SA problems in their churches monthly or more often. Almost two-thirds believed church members usually felt more comfortable receiving pastoral counseling than going to a professional helper. Most clergy stated they would be likely to refer church members to a professional (preferably Christian) counselor if they had a MH or SA disorder. However, important differences were found by education and race/ethnicity. These results indicate that clergy can provide vital education, support, and referrals for parishioners with MH or SA disorders. Christian social workers can strengthen these connections through clergy and congregational education, collaboration, and support services.

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The United States has the highest rates of mental health and substance abuse disorders among developed nations (WHO, World Mental Health Survey Consortium, 2004). Approximately 28% of Americans over the age of 18 suffer from a diagnosable mental or substance abuse disorder (US Department of Health and Human Services (USDHHS), 2001; National Institute of Mental Health, 2009). Approximately 20.9 million Americans have a diagnosable mood disorder such as major depressive disorder, dysthymic disorder, or bipolar disorder (Kessler, Chiu, Demler & Walters, 2005). Over 40 million adults in the United States suffer from anxiety disorders, which frequently co-occur with depressive or substance abuse disorders (Kessler et al., 2005). Substance abuse disorders are also prevalent in the United States, with approximately 23% of American adults reporting that they have engaged in binge drinking (five or more drinks on one occasion) within the past month (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Approximately 7% of the population reported heavy alcohol use (five or more drinks on the same occasion on at least five different days in the past 30 days) (SAMHSA, 2009). Illicit drug use is also common in the United States, with an estimated 20.1 million Americans engaging in illicit drug use in the year 2008. Overall, approximately 22.2 million were estimated to be diagnosable with substance abuse or dependence as specified in the Diagnostic and Statistical Manual IV.

The prevalence and frequency of these mental health disorders and patterns of substance abuse have resulted in numerous adverse outcomes. In 1996, spending for direct treatment of mental health and substance abuse disorders totaled $99 billion, approximately 10% of all national health care spending (USDHHS, 1999). Mental health disorders are one of the leading causes of disability in the United States (Murray & Lopez, 1996). Untreated mental illness and substance abuse/dependency have also been linked to social problems such as crime, intimate partner violence, HIV/AIDS transmission, and adolescent delinquency (Crowe & Bilchik, 1998; RachBiesel, Scott, & Dixon, 1999).

Despite the development of numerous effective medical and psychosocial interventions designed to counteract the effects of mental illness and substance abuse, nearly two-thirds of all individuals with diagnosable mental health disorders do not seek treatment (Regier, Narrow, Rae, Manderscheid, Locke, & Goodwin, 1993; Kessler, Nelson, McKinagle, Edlund, Frank, & Leaf, 1996). This percentage is significantly higher among minority groups (Neighbors, 1985; Neighbors,

Caldwell, Williams, Nesse, Taylor, & Bullard, 2006; U.S. Department of Health and Human Services, 2001). Further, less than 10% of persons who need substance abuse treatment actually receive services (SAMHSA, 2009).

Mental health and substance abuse treatment services are commonly provided by social workers. According to a 2006 study sponsored by the National Association of Social Workers (NASW), "Social workers in behavioral health represent the largest specialty sector within the frontline social work labor force (p. 1)," with mental health representing the most frequent (37%) specialty practice area in social work (NASW Center for Workforce Studies, 2006). According to the Substance Abuse and Mental Health Services Administration (SAMHSA), social workers are the "nation's largest group of clinically trained mental health service providers…providing more mental health services than psychologists, psychiatrists and psychiatric nurses combined (NASW, 2011, p. 1)." However, in spite of this heavy involvement in MH and SA issues, social workers, along with other treatment professionals, are often ignored by those with MH and SA problems.

Barriers to individuals seeking mental health and substance abuse treatment include concerns about cost, stigma surrounding mental health issues, denial of mental health problems, guilt over behaviors, and ignorance about treatment options (USDHHS, 2001). Additional explanations for the low rate of formal mental health services obtained may be the type of help that clients seek and suspicion that treatment will not be effective.

Many individuals first seek help from their own clergy. Two studies have found that between 25-40% of Americans have sought counseling services from clergy (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000; Wang, Berglund, & Kessler, 2003). Data from the National Comorbidity Survey also found that, in a given year, almost one-fourth of those seeking help from clergy for a mental health problem have a serious mental illness but the majority of these persons are only seen by clergy, and not by mental health professionals or other health care providers (Wang et al., 2003).

Clergy are in a unique position to serve as the gatekeepers to mental health and substance abuse services in their communities (Chalfant, Heller, & Roberts, 1990). They are known by the congregant, have less stigma, offer free services, are credible, and they may frame the problem in spiritual terms that are more comfortable for the client (Bohnert,

Perron, Jarman, Vaughn, Chatters, & Taylor, 2010). However, other researchers note that some people may not seek help from clergy for fear that clergy or the congregation may interpret their struggles as spiritual weakness or moral failure (Sternthal, Williams, Musick & Buck, 2010).

Some church members are more likely than others to seek help from clergy. Analysis of General Social Survey data shows that regular church attenders, Biblical literalists, and older persons are all more likely to seek out clergy as a source of advice and assistance. Americans see clergy as less appropriate sources of help for more severe problems such as schizophrenia, and for persons who may be a danger to themselves or others (Ellison, Vaaler, Flannelly, & Weaver, 2006).

It is important for clergy to be aware of their limits and make referrals to trained mental health professionals when necessary. One study has shown that some clergy have difficulty identifying emotional distress or suicidality, particularly in comparison with other mental health professionals (Domino, 1990). Other researchers have expressed concerns about whether clergy can adequately identify persons who are potentially dangerous to others (Weaver, 1992).

Churches can help to dispel the cultural stigma toward mental health and substance abuse services by actively meeting the mental health needs of the community. Research indicates that individuals who attend churches that have a positive attitude toward mental health services have more favorable attitudes toward obtaining help, particularly within minority communities (Clansy, 1998). Examples of such church-based services might include allowing support groups to take place within the church, allowing social workers and other helping professionals to make short presentations or weekend seminars in the church, providing appropriate counseling services within the church, or hiring a case manager to make service referrals.

Although some clergy have expressed a desire to collaborate with helping professionals, there is a discrepancy between their willingness to refer and patterns of referral (Neighbors, Musick, & Williams, 1998). Consequently, it is critical to gain a more extensive understanding of the factors that influence their willingness to make referrals. Broader understanding can, in turn, lead to development of interventions designed to improve access to needed mental health and substance abuse services.

Background for Current Study

In April 2008, representatives of Kent County, Michigan, community mental health centers (CMHC), area clergy, and researchers met to discuss a number of mutual concerns, including the low number of individuals receiving mental health and substance abuse treatment (particularly within the Black and Hispanic communities), lack of service availability, and connections to SA and MH treatment within the community. As a result of this encounter, the primary authors, in conjunction with CMHC representatives and area clergy, developed a survey to assess clergy perceptions of mental health and substance abuse problems within their churches, their actions when faced with mental health or substance abuse challenges within their congregations, and their willingness to refer congregants to mental health and substance abuse professionals.

Because the community mental health providers who co-sponsored the study were interested in using language that clearly identified a broad range of service providers with mental health background, they requested that the survey use the terms *mental health provider*, *substance abuse provider,* and *counselor* when describing the roles of these helping professionals. In addition, these terms were commonly used in the literature, including within measurement instruments. While the group recognized that services could come from a variety of professions (e.g. social work, psychology, counseling, marriage and family therapists, etc.), they chose to focus on terms that clergy would be likely to recognize. These more generic terms were described by their function (i.e. counselor) rather than their profession (e.g. social work). However, as noted above, a large percentage of social workers provide mental health and substance abuse counseling and the absence of the term *social workers* at various points in the study is not meant to suggest any limitation to their wide-ranging roles and involvement with clergy.

Methodology

Target Population

The target population for this survey was clergy from all faith traditions with known e-mail addresses in Kent County, Michigan. This list was originally developed in December 2007, by Dr. Edwin Hernandez, from the DeVos Family Foundations, in partnership with Calvin Col-

lege's Center for Social Research, when the Gatherings of Hope project developed an inclusive list of 720 congregational leaders in Kent County as a way of documenting the social and educational services provided by Kent County congregations (Hernandez, Carlson, Medeiros-Ward, Stek, & Verspoor, 2008). The clergy list was developed using phone books, county church directories, and an exhaustive roadway-grid process where research assistants drove on every road in the county to visually identify and gain contact information for all houses of worship.

For this study we then used the same database as a point of e-mail contact for those same clergy to conduct our online evaluation using SurveyMonkey.com. Since some houses of worship did not use computers, the e-mail list included only 630 addresses, including addresses of administrative staff. As discussed below, although clergy from all faith traditions were contacted, only Christian clergy chose to respond

Survey Development and Content

The online survey, titled "The Grand Rapids Congregational Mental Health and Substance Abuse Survey," is a 57-question survey that was developed by Curtis VanderWaal, Ph.D., in consultation with staff from the DeVos Family Foundations (the funders of this study's survey and the Gatherings of Hope survey), senior leadership at network180 (the Kent County CMHC), and five senior clergy. Following an extensive review of the literature, researchers developed a suggested list of questions relating to clergy perceptions of mental health and substance abuse problems within their churches, their willingness to refer congregants to, or work with, mental health and substance abuse professionals, and their actions when faced with mental health or substance abuse challenges within their congregations. Feedback from the stakeholders listed above resulted in final modifications to the survey.

Data Collection

The first email request to complete the survey was sent from the DeVos Family Foundations in late August, 2009, to approximately 630 clergy and church email addresses, a process which may have created some email redundancy. Two follow-up reminders were sent over the next three weeks. Because of the initial under-representation of both African American and Latino clergy in the survey responses, the DeVos

Family Foundations contracted one African American pastor and one Latino pastor to contact and, in some cases, visit African American and Latino clergy to invite them to complete the survey. In several cases, the survey was translated into Spanish by the Latino pastor so the clergy being interviewed could complete the survey. When the clergy sample for both groups approximately represented the ethnic population within the county, the contracted clergy discontinued data collection. While this approach was unlikely to achieve full statistical representation for these groups, it did allow researchers to adjust for some disparities in ethnic representation. By the end of data collection in January 2010, 215 clergy completed the survey, representing a final response rate of 34%. After final data cleaning, which eliminated partially completed surveys, 179 valid responses remained for analysis. It should be noted that, although the e-mail list contained a very small number of addresses for all known mosques and synagogues in Kent County, none these religious leaders chose to complete the survey, leaving the researchers with a final response set from over 50 Christian denominations.

Findings

In order to gain a better understanding of their personal characteristics, the clergy were asked their sex, race/ethnicity, age, education, religious denomination, and years of service in ministry. The responses are recorded in the following table.

Personal Characteristics of the Clergy

Table 1: Demographic Characteristics of Clergy

Demographic Characteristics	N (%)*
Sex	
Male	152 (88)
Female	21 (12)
Race/Ethnicity	
Black/African American	22 (13)
White/Caucasian	116 (67)
Hispanic/Latino	28 (16)
Other	8 (5)

Demographic Characteristics	N (%)*
Age	
18-29	4 (2)
30-49	67 (39)
50-64	78 (45)
65+	25 (14)
Education	
GED/HS Diploma	12 (8)
AS, BS	30 (17)
MA, MS, MDIV	102 (59)
Dmin, PhD, MD, JD	23 (13)
Other	5 (3)
Religious Denomination	
Evangelical	31 (18)
Reformed	60 (35)
Pentecostal or Charismatic	27 (16)
Mainline or other Protestant	9 (5)
Catholic or Orthodox	21 (12)
Other Traditions	23 (13)
Years in Ministry	
Less than 5 years	8 (5)
5-10 years	37 (21)
11-20 years	49 (28)
21-30 years	79 (45)

*Due to rounding, some percentages do not add up to 100%

Table 1 shows that the large majority of respondents (88%) were male. Two-thirds (67%) of the clergy were White or Caucasian, 16% were Hispanic/Latino, 13% were African-American/Black, and 5% were Other. Clergy from diverse ethnic backgrounds represented around one-third of the respondents.

Almost half (45%) of those surveyed were between the ages of 50-64, with more than one-third (38.5%) of the respondents between the ages of 30-49. Over 14% were above the age of 65. Only 2.3% of respondents were between the ages of 18-29 years.

Overall, the clergy in Kent County were well educated. Almost three-fifths (59%) of the respondents possessed a Master of Divinity degree or other Master's degree, and another 13% possessed a doctoral degree (D.Min./Ph.D./M.D./J.D.). The remaining clergy had a Bachelor's or Associate's degree (17%), GED/High school diploma (8%), or Other degree (3%).

Respondents were also asked to identify their religious denomination. Clergy were allowed to self-select their religious tradition and re-

searchers then combined categories into larger, more general categories. These groupings were made using criteria developed and applied in the recent Gatherings of Hope study of congregations in Kent County. As reported in Table 1, about one-third (35%) of the clergy were from the Christian Reformed tradition, 18% were Evangelical, 16% reported being Pentecostal or Charismatic, 12% of the respondents were Catholic or Orthodox, and 13% were categorized as Other Traditions (e.g. Mormon, Jehovah's Witnesses, etc.). The remaining 5% responded Mainline or Other Protestant.

Clergy respondents were asked the number of years they had worked in professional ministry. Almost half (45%) of respondents had served between 21-30 years. Over 28% had been in ministry between 11-20 years, and the remaining one-fourth (26%) of the respondents had served for a total of 10 years or less.

Knowledge and Beliefs about Mental Health Issues

The respondents' knowledge and beliefs about mental health issues are displayed in Table 2.

Table 2: Respondent Knowledge and Beliefs about Mental Health Issues*

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
I can recognize a person with a serious mental health challenge.	0.6%	0.6%	12.4%	65.1%	21.3%
I believe that persons with a serious mental health challenge could be possessed by demons.	11.2%	23.7%	27.8%	33.7%	3.6%
I believe that persons with a mental health challenge are often imagining their problems.	26.6%	55%	11.2%	5.9%	1.2%
I believe there is a biological or physical basis for mental health challenges.	1.8%	1.8%	21.8%	56.5%	18.2%
I would encourage a church member to stop taking medication for a mental health challenge in favor of seeking spiritual healing.	53.5%	27.6%	9.4%	4.7%	0.6%

	Strongly disagree	Disagree	Not sure	Agree	Strongly agree
I believe that a church member often lacks faith when they are going through a mental health challenge.	57.6%	27.6%	9.4%	4.7%	0.6%
I have not referred church members to mental health services because of fears that confidentiality may be broken.	63.1%	30.4%	3%	3%	0.6%
I believe that church members often can't afford mental health services.	3.5%	12.9%	14.1%	48.2%	21.2%
I believe church members usually feel more comfortable receiving pastoral counseling than going to a mental health profession.	2.3%	9.9%	24.6%	50.9%	12.3%
I believe that church members may choose not to seek mental health services because of the stigma attached to seeking therapy.	4.1%	7.6%	10%	62.4%	15.9%

*Shaded cells indicate the category with the highest percentage of respondents.

A large majority of clergy (86%) believed they could recognize a person with a serious mental health challenge. When clergy were next asked how strongly they believed that persons with serious mental health issues could be possessed by demons, more than one-third (37%) of clergy *Agreed* or *Strongly Agreed* with the statement, while approximately the same amount (35%) *Disagreed* or *Strongly Disagreed.* The remaining 28% of respondents were *Not Sure.* As a side note, we believe the question should have been worded more clearly to indicate the extent to which clergy believed serious mental illness *likely to be caused by* demon possession. The current wording allows for a broad interpretation that probably invited more clergy to agree or be uncertain than might have been the case with a more cleanly defined question.

Overall, most clergy favored a more medical understanding of mental illness. A large majority strongly agreed that people with mental health challenges were *not* just imagining their symptoms (82%), that there was a biological or physical basis for mental illness (75%), and that they would not encourage their members to stop taking medications for their mental health issues in favor of spiritual healing (80%). Somewhat

similarly, a strong majority (85%) did not believe that church members lacked faith when they were experiencing a mental health challenge.

A large majority of clergy believed that stigma (78%) or financial cost (69%) could prevent their members from seeking help from a mental health professional. About half the clergy believed that church members generally felt more comfortable receiving pastoral counseling rather than going to a mental health professional.

Frequency of Problems Experienced by Church Members

In order to gain a better understanding of the frequency of various mental health and substance abuse issues that the clergy encountered on a regular basis, respondents were asked to respond to the following question, "*In my role as a pastor, I encounter the following problems with church members or people in the community…:* The problems included: 1) mental health challenges; 2) substance abuse challenges; 3) violence (family or community); 4) sexual abuse; and 5) marriage and family problems.

Table 3: Problem Areas Identified by Clergy*

In my role as a pastor, I encounter the following problems with church members or people in the community:	Almost never	A few times a year	Monthly	Weekly	Almost every day
Mental health challenges.	5.8%	38.4%	24.4%	22.1%	9.3%
Substance abuse problems.	8.8%	35.3%	29.4%	16.5%	10%
Violence (family or community).	25.6%	47.1%	18%	5.8%	3.5%
Sexual abuse.	37.8%	46.5%	12.2%	2.3%	1.2%
Marriage and family problems.	1.2%	23.1%	32.9%	32.9%	9.8%

* Shaded cells indicate the category identified by the highest percentage of respondents.

As indicated in Table 3, the most common problem area that clergy encountered was *Marriage/Family* problems, with approximately 43% of respondents encountering such problems *Weekly* or *Almost Everyday. Mental Health Challenges* were also relatively common, with 31% of respondents encountering this issue *Weekly* or *Almost Everyday.* Approximately 27% of respondents reported encountering substance abuse *Weekly* or *Almost Everyday,* while 9% encountered *Violence,* and 3% encountered *Sexual Abuse.* These results indicate that *Marriage/Family Problems* and *Mental Health Challenges* are the most common

issues among church members, while *Violence* and *Sexual Abuse* are encountered less frequently by clergy.

In addition, researchers examined whether pastors from some ethnic or racial groups were more likely to encounter certain problems more frequently than other groups. Chi square analyses were conducted on each of the questions by race/ethnicity. Compared to Caucasian and Hispanic clergy, African-American pastors were significantly more likely to encounter substance abuse problems on an almost daily basis ($p < .05$). Specifically, over one-fourth (29%) of African-American clergy encountered church members or people in the community with substance abuse problems almost every day, compared to 7% of both Caucasian and Hispanic/Latino clergy. Both African-American and Hispanic/Latino clergy encountered issues of family or community violence significantly more often than Caucasian clergy ($p < .001$). Over half (55%) of African-American clergy and 50% of Hispanic/Latino clergy encountered violence issues with church members or people in the community on a monthly or more frequent basis. Furthermore, compared to Caucasian clergy, marriage and family problems were more frequently reported by both African-American and Hispanic/Latino pastors ($p = .003$). Almost one-fourth (23%) of African-American clergy and almost one-fifth (19%) of Hispanic/Latino pastors encountered church members with marriage and family problems almost every day, compared to 5% of Caucasian clergy. Analyses that did not show statistical significance by race/ethnicity were 1) mental health challenges and 2) sexual abuse.

Willingness of Clergy to Make Referrals

Clergy were asked to indicate whether they would be likely to refer church members to a mental health professional for a specific problem (Table 4). The question stated, "*I would be likely to refer church members to a mental health professional (counselor) if they have problems with….*" Issues for which ministers were highly likely to make a referral were *Nervous Breakdowns* (90%), *Domestic Violence* (86%), *Sexual Abuse* (86%), *Depression (83%)* and *Alcohol/Drug Addiction* (82%). Approximately half of the respondents were likely to refer church members with *Anger (64%), Anxiety* (58%), *Marital Relationship* (56%), *Parenting* (54%), *and Adjusting to Life* (48%) problems. Respondents were least likely to refer church members for issues relating to *Racism/Discrimination* (33%), *Finances* (32%), and *Work* (28%).

Table 4: Willing to Refer Church Members to Counselor

High Level of Willingness		Moderate Level of Willingness		Low Level of Willingness	
Nervous Breakdown	90%	Anger	64%	Racism/ Discrimination	33%
Domestic Violence	86%	Anxiety	58%	Finances	32%
Sexual Abuse	86%	Marital Relationship	56%	Work	28%
Depression	83%	Parenting	54%		
Alcohol/Drug Addiction	82%	Adjusting to Life	48%		

Each of these issues was analyzed by race/ethnicity to explore significant cultural differences. Five of the thirteen categories expressed statistically significant differences. Caucasian (67%) and Hispanic/Latino (46%) clergy were significantly more likely to refer a congregant who was experiencing marital problems to a helping professional, while only one-fourth (27%) of African-American clergy said they would be likely to make a referral ($p < .000$). Similar findings emerged with depression issues. Approximately 90% of Caucasian clergy and 85% of Hispanic/Latino clergy stated they would be likely to refer a church member with depression to a mental health professional, while only 55% of African-American clergy stated they would make a referral ($p = .005$).

When asked if they would be likely to refer congregants experiencing problems with racism and discrimination, Hispanic/Latino clergy (58%) were significantly more likely than African-American or Caucasian clergy to make the referral ($p = .001$). Similarly significant findings were found with clergy referrals for financial issues. Approximately 59% of Hispanic/Latino clergy responded that they would be likely to refer church members with financial difficulties while only 29% of Caucasian and 27% of African-American clergy indicated they would be likely to refer for this issue ($p = .003$).

The final question in this sequence asked respondents to state whether they would be likely to refer church members to a mental health professional if they were experiencing problems at work. The results remained consistent, with significantly more Hispanic/Latino clergy (46%) indicating they would be willing to make a referral ($p = .002$).

Between 80-90% of clergy were likely to make a referral for depression, nervous breakdowns, domestic violence, sexual abuse, and alcohol/

drug addiction. Approximately half of the respondents were likely to refer church members with anxiety, marital relationships, anger, parenting, and adjusting to life problems. Fewer than one-third were likely to refer church members for issues relating to racism/discrimination, finances, and work-related issues.

Preferences for Consulting, Collaborating, and Referral Relationships

The next section of the survey explored the pastors' willingness to consult, collaborate, or refer congregants with problems to mental health professionals.

Table 5: Preferences for Consulting, Collaboration, and Referral Relationships*

	Not likely at all	Un-likely	Not sure	Likely	Very likely
I would allow a mental health professional to present a seminar in my church.	1.8%	1.8%	8.8%	42.7%	45%
I would allow a mental health professional to lead a support group in my church.	2.9%	1.8%	13.5%	34.1%	47.6%
I would allow a mental health professional to have an office in my church.	9.4%	12.3%	26.9%	26.3%	25.1%
I would welcome the invitation to work together on a community service outreach project with a mental health professional.	4%	7.5%	20.2%	45.7%	22.5%
I feel my role as a pastor or leader would be compromised or devalued by the involvement of a mental health professional within the congregation.	58.1%	30.8%	4.7%	4.1%	2.3%
As a pastor, I would consult with a mental health professional about a church member's mental health issue.	0.6%	1.7%	6.4%	38.4%	52.9%
I would consider making a referral to a mental health professional when the circumstances are beyond the scope of my knowledge and/or expertise.	0.6%	2.3%	1.7%	13.4%	82%

I would prefer consulting with a mental health professional who is the same ethnicity as me.	49.9%	21.8%	19.4%	8.2%	7.6%

* Shaded cells indicate the category identified by the highest percentage of respondents.

Table 5 shows that clergy were quite comfortable partnering with counselors around mental health issues. Almost 90% were willing to allow a counselor to present a seminar in their church and 82% would allow them to lead a support group in the church. Although less likely, over half of all clergy were willing to allow a mental health professional to have an office in their church. When asked if they felt that their role in the church would be devalued or compromised by the involvement of a mental health professional, a large majority of clergy (89%) responded *Unlikely* or *Not Likely at All.*

When asked about consulting with a mental health professional about a church member's mental health issues, a significant majority (91%) responded that they were *Likely* or *Very Likely to do this. Similarly, when asked if they were willing to make a referral* to a mental health professional when the circumstances were beyond their knowledge and/or expertise, over 95% of clergy affirmed their willingness to do so.

Respondents were then asked if they would prefer consulting with a mental health professional of the same ethnicity as themselves. Almost three-fourths (72%) of clergy responded they would be *Unlikely* or *Not Likely at All* to prefer this option. However, some important variations in this question emerged when comparisons were made by ethnicity and education level. Half of both African-American (50%) and Hispanic/Latino (48.1%) clergy responded that they were *Likely* or *Very Likely* to prefer this option, while only 1.7% of Caucasian clergy responded they would be likely or very likely to prefer consulting with a mental health professional of the same ethnicity ($p < .000$). Clergy with lower levels of education (GED/HS diploma and AS/BS college degrees) were also significantly more likely than those with higher educational training to prefer consulting with a mental health professional of the same race or ethnicity ($p = .013$).

In Table 6, clergy were asked about the importance of a referral source's Christian faith, denominational affiliation, and ethnic or racial background. Over 85% of clergy felt it was important that the counselor was a Christian, whereas only 15% believed that denomination was an important factor in making a referral. A similar percentage (14%) was unconcerned about the ethnic or racial background of the referral source.

Table 6: Clergy Preferences Regarding Religious and Ethnic/Racial Characteristics of Referral Professionals*

If you were to refer someone to a professional counselor for substance abuse or mental health challenges, how important is it that the counselor…	Not important at all	Somewhat important	Not sure	Important	Very Important
…is a Christian?	3.5%	8.1%	2.9%	25%	60.5%
…is the same denomination as your church?	49.4%	27.4%	8.3%	12.5%	2.4%
…has the same ethnic or racial background as your church member?	54.4%	21.3%	10.1%	8.3%	5.9%

* Shaded cells indicate the category identified by the highest percentage of respondents.

The findings presented in Table 7 indicate responses to a question relating to how the respondent would react if a church member were experiencing a serious mental health challenge. No definition for this challenge was given.

Table 7: Clergy Response to Person with a Serious Mental Health Challenge*

If one of your church members or persons you know was experiencing a serious MENTAL HEALTH CHALLENGE, how likely would you be to do the following:	Not likely at all	Unlikely	Not sure	Likely	Very likely
Give them prayer and spiritual counseling only.	35.7%	44.4%	4.1%	8.2%	7.6%
Refer them to a hospital emergency room.	5.9%	20%	28.2%	36.5%	9.4%
Refer them to a medical doctor.	4.1%	16.5%	17.6%	45.3%	16.5%
Refer them to a mental health counselor.	1.2%	0.6%	4.2%	47%	47%

Refer them to another pastor who has more training or experience.	14.2%	26%	27.8%	27.8%	4.1%

***** Shaded cells indicate the category identified by the highest percentage of respondents.

As demonstrated in Table 7, respondents were most likely to refer a church member to a mental health counselor (94%) or medical doctor (62%). Almost half (46%) of respondents were *Likely* or *Very Likely* to refer their church member to a hospital emergency room, however almost one-third were *Not* Sure, most likely because it would depend on the severity of the crisis. Almost one-third (32%) were *Likely* or *Very Likely* to refer congregants to another pastor with more experience, and only 16% were *Likely* or *Very Likely* to offer only prayer and spiritual counseling.

The final two questions asked respondents to state the number of referrals they had made within the past six months. Table 8 demonstrates the number of referrals made to a local mental health counselor or counseling center. Although less than one-third (30%) had not made any referrals in the past six months, almost half (47%) of the respondents reported making 1-5 referrals within the past six months, 7% reported referring six or more people to a local mental health/counseling center.

Table 8: Frequency of Referrals to Mental Health Counselor or Counseling Center

In the past six months, approximately how many people have you referred to a local mental health counselor or counseling center?	Percent of respondents
0 persons	29.9
1-5 persons	47.1
6-10 persons	15.5
11-15 persons	3.4
16-20 persons	3.4
More than 20 persons	.6

Table 9 reflects the number of referrals made to a substance abuse counselor or drug treatment center. Although almost half (49%) did not make any referrals, over one-third (40%) reported making 1-5 referrals, 8% reported having referred between 6-10 people, and 3% reported making 11 or more referrals in the past six months.

Table 9: Frequency of Referrals to Substance Abuse Counselor or Drug or Alcohol Treatment Center

In the past six months, approximately how many people have you referred to a local substance abuse counselor or drug or alcohol treatment center?	Percent of respondents
0 persons	48.9
1-5 persons	40.2
6-10 persons	7.5
11-15 persons	1.7
16-20 persons	0.6
More than 20 persons	1.1

Discussion

Because clergy are often on the front lines when individuals and their families are dealing with a mental health crisis, it is potentially encouraging to see that the strong majority of clergy believed they could recognize such a crisis. However, as noted earlier, some studies have shown that some clergy have difficulty identifying emotional distress, suicidality, or danger to others (Domino, 1990; Weaver, 1992). Clergy also generally understood that church members often prefer help and support from their clergy more than from the formal mental health community, perhaps due to issues of trust, stigma, and finances.

It is also encouraging to see that most clergy favored a biological or physical explanation for serious mental illness. As such, they were generally supportive of medication usage and did not think church members were imagining their symptoms or were lacking in faith. However, it is important to note that clergy's ideas about the causes of a serious mental illness are undoubtedly complex, with possible interactions of spiritual struggles and chemical imbalances that could exacerbate symptoms. Despite these complexities, however, the recognition of a possible biological cause appears to often translate into a referral to a mental health professional when the issue becomes serious.

Around a third of clergy believed that serious mental health challenges could be caused by demons, with some groups supporting this belief more strongly. However, this is a complex question that undoubtedly varies by denomination, education level, and personal belief system. For example, Catholics, actually have careful protocols for dealing

with demon possession that require that a person be determined to be free of a DSM diagnosis by a licensed psychiatrist (Allen, 2000). Such complexity requires a great deal more understanding before any clear conclusions could be reached. However, it may highlight an area where further education could help clergy better understand the complex factors involved in mental illness, particularly for those conditions that can trigger psychotic thoughts and behaviors. For example, some helping professionals have compared "normal" images of brain functioning with those of persons who are experiencing a mental health challenge as a way of helping pastors to see the biological differences in a visual way. It may also be helpful for clergy to understand the role that medications can play in managing brain diseases that can generally be controlled with proper medical care and medication compliance on the part of the individual with mental health challenges. Within this context, prayer and pastoral counseling can be very helpful, but should not be considered a substitute for professional psychiatric care.

Clergy regularly encounter serious and challenging family problems, mental health challenges, and substance abuse issues. Substance abuse and violence were more common among minority communities. Such differences are more often seen within communities that experience higher levels of economic challenges, a phenomenon more common among African American and Hispanic communities.

Clergy were highly likely to make referrals for issues that they viewed as more serious in nature, such as depression, nervous breakdowns, domestic violence, sexual abuse, and alcohol/drug addiction. They likely recognized these issues as often being beyond their scope of training and expertise and were willing to send church members to mental health professionals for further help. Willingness to refer dropped to about 50% with issues relating to anxiety, marital relationships, anger, parenting, and adjustment to life problems. Such a reduction possibly reflects what clergy might consider to be less serious problems that they can more often handle without outside assistance. Issues considered to be least serious, including racism/discrimination, financial difficulties, or problems at work, were also least likely to be referred for counseling, possibly again reflecting clergy willingness to comfortably handle these issues on their own.

The majority of clergy expressed willingness to consult and even collaborate with mental health professionals, both within and outside of their churches. For example, most clergy were willing to allow mental health professionals to present seminars or lead out in support groups in

their churches, with around one-half willing to collaborate on community service outreach projects, and about one-third even willing to allow a mental health professional to have an office within their church. Contrary to those who might say that clergy are often suspicious of professional counselors and reluctant to collaborate with them, these findings show that clergy are generally open to working with counselors and find value in their training and expertise, particularly when they are identified as being Christian. This preference provides important opportunities for Christian social workers to develop or expand their relationships with local clergy as educational resources, collaborators, or service providers.

While almost none of the Caucasian clergy felt a need to consult with a counselor of the same ethnic background, about half of all Hispanic/Latino and African American clergy preferred this opportunity. This finding was particularly strong among clergy with lower levels of education. This is consistent with prior studies in this area and likely reflects concerns by clergy of color that counselors who do not look like them may not be able to understand the perspectives, challenges, and cultural traditions of their church members.

While having a Christian counselor was important, a large majority of clergy considered a counselor's denomination to be relatively unimportant. However, African American and Hispanic/Latino clergy were much more likely to consider this to be an important issue, perhaps reflecting their desire for a counselor who was culturally similar to their church members. The desire for a counselor who understood the church members' doctrinal beliefs may have played some role in this preference as well. Such findings highlight the importance of developing a network of culturally competent, preferably Christian referral sources to which clergy of color can comfortably send their church members. This may require that professionals in the mental health and substance abuse communities develop a resource list and begin the process of networking clergy with those culturally competent professionals.

When clergy were asked how they would handle a church member with a serious mental health challenge, almost all clergy said they would make a referral to a mental health counselor. About two-thirds also said they would make a referral to a medical doctor, with less than half making a referral to an emergency room. The variation in these responses, combined with one-third of clergy who were *Not Sure*, likely shows that clergy wish to consider the nature of the problem before deciding where to refer their church member. Very few of the clergy indicated that they

would only offer prayer and spiritual counseling, likely indicating that most clergy understood the limits of sometimes narrow spiritual solutions to serious physical and mental problems. Their overwhelming willingness to refer someone with a serious problem and their generally strong reluctance to offer only spiritual help indicate that the clergy understand that the complexity of serious mental health challenges is best handled by professionals.

In addition, as noted above, less than one-third had not made any mental health referrals and less than one-half had not made any substance abuse referrals. However, almost half of the clergy reported making 1-5 mental health referrals and one-third had made 1-5 substance abuse referrals in the past six months. Since we did not ask clergy to estimate the total number of church members they actually saw with serious mental health issues in the past six months it is difficult to tell whether they are referring a few, some, most, or all of these individuals to a mental health agency or professional. Further, it is unclear how many Christian counselors were used in the referral process. However, it is important for clergy to understand how to identify someone with a mental health or substance abuse challenge, to provide appropriate support to those individuals within their training and comfort level, and to be aware of resources available to them when a church member experiences a crisis. This awareness includes knowing when and who to call in such circumstances. Developing a collaborative network of referral sources that are known, trusted, competent, and preferably Christian would likely increase the levels of referrals and would lower the stigma associated with mental illness as clergy increased their understanding, support and referral of these church members.

Limitations and Next Steps

Several issues limit the scope of this study. First, although the sample size was relatively large and the response rate was adequate, the sampling frame was limited to one Midwestern county, with particularly high rates (35%) of well-educated Dutch Reformed clergy. This group represents a particular denominational and educational perspective, thus potentially skewing the data and limiting generalizability of the findings on a national level.

Second, the use of the terms *mental health professional, substance abuse professional, and counselor*, as opposed to broader terms such as *helping professional* or even *social worker* may have narrowed the way

in which clergy thought about the scope of human service professionals who were qualified and capable of providing mental health and substance abuse services. For example, the survey asked clergy whether they would refer problems relating to finances to a mental health professional. This language clearly limits the choice of clergy to make referrals to budgeting coaches, financial counselors, or other types of helping professionals. Future surveys will need to create more inclusive language to more accurately reflect the broader professional community that is active in providing such services.

Third, issues relating to mental health and substance abuse are complex and multi-dimensional. Hypothetical decisions about what sorts of problems to refer and under what circumstances are naturally limited by clergy self-definitions, (mis)understandings and (mis)perceptions of terms such as *serious mental health challenges* and *substance abuse problems*. As such, the findings should be treated with appropriate caution.

Finally, some findings require more exploration and nuanced understanding. As such, next steps include multivariate analyses that control for age, gender, race/ethnicity, denomination, years in ministry, education, and hours of counseling training.

Conclusions and Recommendations

Christian social workers have a unique opportunity to provide competent, spiritually aware training and education to clergy and their congregations. When providing such assistance, social workers should consult with clergy and gain their input into the development and presentation of training and educational materials. In addition, by providing additional training in mental health education and collaboration, Christian social workers can strengthen connections with religious leaders, particularly among less educated and minority clergy.

Another important way Christian social workers can help churches deal with mental health and substance abuse challenges is to provide culturally competent counseling services to these congregations. As noted earlier, social workers provide a majority of professional mental health services. As clergy search their communities for Christian counselors, Christian social workers must continue to look for ways to increase the utilization of mental health services within the religious community, particularly among ethnic minorities.

As a bridge to services, clergy can play a key role in connecting

members to spiritually sensitive mental health and substance abuse services (Chalfant et al., 1990). Some congregants are suspicious of mental health professionals, resulting in the underutilization of services (U.S. Department of Health and Human Services, 2001). Providing Christian-based mental health services such as support groups at church and using the church to promote the use of mental health and substance abuse counseling services may increase utilization of these services (Pickett-Schenk, 2002). Collaboration with clergy is one way to remove some of the existing barriers to mental health services and to increase culturally competent service options. Improving these collaborative relationships could go a long way toward ensuring that persons with mental health and substance abuse challenges get the help they need within a relationship that values their faith and provides appropriate treatment. ❖

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