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The Gatekeepers: An Evaluation of Clergy Knowledge, Attitudes, and Perceptions Regarding Mental Health Issues, Collaboration, and Referral to Treatment

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Abstract

The data from which this analysis originates is part of a an evaluation project which was designed to assess how clergy from various denominations collaborate with mental health service providers and refer church members to needed services. A survey of 215 clergy in Kent County, Michigan was conducted to gain a better understanding of clergy knowledge and perceptions of mental illness and their willingness to make referrals to mental health professionals. Initial frequencies, bivariate and Chi-square analyses were conducted using SPSS v. 16. Findings indicate that, compared to Caucasian clergy, ethnic minority clergy were less willing to make referrals and collaborate with mental health professionals. Less educated and minority clergy may benefit from additional training in mental health education and referral to treatment. It is further recommended that treatment providers strengthen connections with minority clergy by educating and collaborating with them around mental health education, support and referral.

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Background

The United States has the highest rates of mental health and substance 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, 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. These 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 engaging 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. Of these individuals, approximately 22.2 million were diagnosed with substance abuse or dependence as specified in the DSM-IV (SAMHSA, 2009). In addition, the overall rate of illicit drug use among individuals over the age of 12 increased from 8.0% in 2008 to 8.7% in 2009 (SAMHSA, 2009).

The prevalence and frequency of these mental health disorders and patterns of substance abuse have resulted in numerous adverse outcomes. In 1990, the indirect costs of mental illness (morbidity costs and loss of productivity) resulted in a $79 billion loss (Rice & Miller, 1996). Spending for direct treatment of mental health and substance abuse disorders totaled $99 billion,

approximately 10% of all national health account spending (U.S. Surgeon General, 2000). 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 intimate partner violence, HIV/AIDS transmission, and adolescent delinquency (Crowe & Bilchik, 1998; RachBiesel et al., 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 et al., 1993; Kessler et al., 1996). This percentage is significantly higher among minority groups (Neighbors, 1985; Neighbors et al. 2006; US Department of Health and Human Services, 2001).

Barriers to mental health treatment include concerns about cost, stigma surrounding mental health issues, denial of mental health problems, guilt over behaviors, and ignorance about treatment options (US Department of Health and Human Services, 2001). One additional explanation for the low rate of formal mental health services obtained may be the type of help that clients seek. Many individuals first seek help from their own clergy (Wang, Berglund, Kessler, 2003). A recent study indicated approximately 39% of Americans seek counseling services from clergy (Taylor, Ellison, Chatters, Levin & Lincoln, 2000). Clergy are in a unique position to serve as the gatekeepers to necessary resources and mental health services in their communities (Chalfant et al., 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 et al., 2010).

It is important for clergy to be aware of their limits and make referrals to trained mental health professionals when necessary. Churches can also help to dispel the cultural stigma

towards mental health services by actively meeting the mental health needs of the community. Research indicates that individuals who attend churches with a positive attitude toward mental health services have more favorable attitudes toward obtaining help (Clansy, 1998). Examples might include allowing support groups to take place within the church, allowing mental health 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. Extant literature indicates that although clergy have expressed a desire to collaborate with mental health professionals, there is a discrepancy between their willingness to refer and patterns of referral (Neighbors et al., 1999). 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.

Methodology

Measure

In 2009, 630 members of the clergy in Kent County, MI were invited to participate in an electronic survey entitled The Grand Rapids Congregational Mental Health and Substance Abuse Survey. The survey was designed to explore clergy knowledge and perceptions of mental health issues, as well as the role clergy play in providing mental health services and referrals to their congregants. The survey consisted of six sections and a total of 57 questions. Participants were asked questions regarding their background information, their willingness to consult or collaborate with mental health professionals, their knowledge and experience with mental health and substance abuse issues, their willingness to make mental health referrals, their perceptions of mental health issues, and past actions related to mental health and substance abuse referrals.

Although the survey included 57 questions, this analysis will consider only a portion of these variables. Independent variables include 1) knowledge of mental health issues; 2) attitudes and perceptions of mental health problems; 3) willingness to make referrals to mental health professionals; and, 4) number of mental health and substance abuse referrals made to agencies within past six months. Dependent variables in this analysis will consist primarily of demographic information, including 1) age; 2) gender; 3) ethnicity; 4) religious denomination; 5) years in ministry; 6) education; and 7) counseling and collaboration training.

The survey was distributed using an electronic mailing list from a recent census of Kent County churches conducted by Dr. Edwin Hernandez and the DeVos Family Foundations (Hernandez et al., 2008). This comprehensive database of known clergy in Kent County, MI was developed using phone books, regional church directories, and grid network analysis.

Email invitations to participate in online survey were sent to approximately 630 clergy email addresses. The invitations outlined the purpose of the survey and included a link to the online survey software program SurveyMonkey was included. Participants were given informed consent and ensured their responses would be kept confidential. Two follow-up letters were emailed one week and two weeks later to remind participants to complete the survey.

Sample

Two hundred fifteen clergy, representing over 50 Christian denominations, completed the survey, resulting in a final response rate of 34%. After the data was cleaned, 173 complete survey responses were used for all analyses. Additionally, researchers conducted in-person visits to Black and Hispanic churches to increase the sample size of the largest ethnic clergy groups. The following figures outline the demographic composition of the population surveyed.

Figure 1
Demographic Characteristics

Characteristics	n(%)
Gender	
Male	152(87.9)
Female	21(12.1)
Race/Ethnicity	
Asian	2(1.1)
Native American	2(1.1)
Black/African American	22(12.6)
White/Caucasian	116(66.7)
Hispanic/Latino	28(16.1)
Multi-racial	3(1.7)
No Answer	1(0.6)
Age	
18-29 years	4(2.3)
30-49 years	67(38.5)
50-64 years	78(44.8)
56 or more years	25(14.4)
Religious Denomination	
Evangelical	31(17.8)
Reformed	60(34.5)
Pentecostal or Charismatic	27(15.5)
Mainline or Other Protestant	9(5.2)
Catholic or Orthodox	21(12.1)
Other Traditions	23(13.2)
Years in Ministry	
Less Than 5 Years	8(4.6)
5-10 Years	37(21.3)
11-20 Years	49(28.2)
21-30 Years	79(45.4)

Analysis

Initial frequencies and bivariate analyses were conducted using SPSS v. 16. Chi-square analyses were used to determine relationships between the dependent and independent variables. Statistical significance was evaluated using a .05 level of significance, two-tailed.

Results

Mental Health Issues Encountered

In order to gain a better understanding of the frequency of the various types of issues that ministers encountered on a regular basis, participants 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…:* These problems included: 1) mental health challenges; 2) substance abuse challenges; 3) violence (family or community); 4) marriage and family problems; and 5) sexual abuse. As indicated in Figure 3, the most common mental health issue clergy encountered was *Marriage/Family* problems, with approximately 43% of respondents reporting encountering such problems *Weekly* or *Almost Every Day. Mental Health Challenges* were also relatively common, with 31.4% of participants encountering this issue *Weekly* or *Almost Every Day.* Approximately 26.5% of ministers encountered substance abuse *Weekly* or *Almost Every Day,* while 9.3% encountered *Violence,* and 3.4% encountered *Sexual Abuse.* These results indicate that *Marriage/Family problems* and *Mental Health challenges* are the most common issues presented by church members, while *Violence* and *Sexual Abuse* are encountered less frequently by ministers.

Figure 3

In my role as a pastor I encounter the following problems with church members or people in the community…

Characteristics	Monthly	Weekly	Almost Every day
Mental Health Issues	24.4%	22.1%	9.3%
Substance Abuse Issues	29.4%	16.5%	10%
Violence	18%	5.8%	3.5%
Marriage and Family	32.9%	32.9%	9.8%
Sexual Abuse	12.2%	2.3%	1.2%

In addition, chi-square tests were conducted to determine whether pastors from specific ethnic or racial groups were more likely to encounter certain problems more frequently than clergy from other groups. Analyses were conducted on each of the questions in Figure 3 by race/ethnicity, with the following statistically significant findings:

Figure 4

In my role as a pastor, I encounter the following problems with church members or people in the community: Substance Abuse (N = 170)

	A Few Times a Year	Monthly/Weekly	Almost Every Day
Race/Ethnicity**	**%**	**%**	**%**
African-American	**23.8**	**47.6**	**28.6**
Caucasian	**35.7**	**46.1**	**7.0**
Hispanic/Latino	**32.2**	**53.9**	**7.7**

Note: **p > .001

Compared to Caucasian and Hispanic clergy, African-American pastors were significantly more likely to encounter substance abuse problems on an almost daily basis. Specifically, over one-fourth (28.6%) 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.

While only 18.0% of clergy encountered family or community violence problems among congregants or people in the community on a monthly basis (Figure 3), both African-American and Hispanic/Latino respondents encountered issues of family or community violence significantly more than their Caucasian counterparts (Figure 5). Over half (54.6%) 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.

Figure 5

In my role as a pastor, I encounter the following problems with church members or people in the community: Violence (N = 170)

	Monthly	Weekly	Almost Everyday
Race/Ethnicity**	**%**	**%**	**%**
African-American	**27.3**	**18.2**	**9.1**
Caucasian	**15.5**	**1.7**	**0.9**
Hispanic/Latino	**26.9**	**15.4**	**7.7**

Note: **p > .001

In addition, when compared to Caucasian clergy, marriage and family problems were seen more frequently by both African-American and Hispanic/Latino pastors.

Figure 6

In my role as a pastor, I encounter the following problems with church members or people in the community: Marriage and Family Problems (N = 170)

	Monthly	Weekly	Almost Every Day
Race*	**%**	**%**	**%**
African-American	**31.8**	**36.4**	**22.7**
Caucasian	**37.1**	**33.6**	**5.2**
Hispanic/Latino	**18.5**	**37.0**	**18.5**

Note: *p > .005

Nearly one-fourth (22.7%) of African-American clergy and one-fifth (18.5%) of Hispanic/Latino pastors encountered church members with marriage and family problems almost every day, compared to 5.2% of Caucasian clergy.

Willingness to Make Referrals

The subsequent series of questions asked ministers to state whether they would be likely to refer church members to a mental health professional for a specific mental health issue. The question stated, *"I would be likely to refer church members to a mental health professional (counselor) if they have problems with…"* The results are listed in Figures 7 and 8.

Figure 7

I would be likely to refer church members to a mental health professional (counselor) if they have problems with…

Characteristics	**n(%)**
Anxiety	
Yes	100(57.5)
Maybe	60(34.5)
No	11(6.3)
Marital Relationship	
Yes	97(55.7)
Maybe	53(30.5)
No	21(12.1)
Anger	
Yes	112(64.4)
Maybe	47(27.0)
No	12(6.9)
Depression	
Yes	145(83.3)
Maybe	23(13.2)
No	4(2.3)
Sexual Abuse	
Yes	149(85.6)
Maybe	15(8.6)
No	5(2.9)
Domestic Violence	
Yes	149(85.6)
Maybe	13(7.5)
No	7(4.0)
Alcohol/Drug Addiction	
Yes	143(82.2)
Maybe	18(10.3)
No	9(5.2)
Nervous Breakdown	
Yes	156(89.7)
Maybe	7(4.0)
No	3(1.7)

Figure 8

I would be likely to refer church members to a mental health professional (counselor) if they have problems with…

Characteristics	**n(%)**
Parenting	
Yes	94(54.0)
Maybe	62(35.6)
No	15(8.6)
Adjusting to Life	
Yes	84(48.3)
Maybe	62(35.6)
No	24(13.8)
Racism and Discrimination	
Yes	57(32.8)
Maybe	79(45.4)
No	34(19.5)
Finances	
Yes	56(32.3)
Maybe	64(36.8)
No	51(29.3)
Work	
Yes	49(28.2)
Maybe	78(44.8)
No	43(24.7)

As seen in Figures 7 and 8, issues for which ministers were most likely to make a referral were *Nervous Breakdowns* (89.7%), *Domestic Violence* (85.6%), *Sexual Abuse* (85.6%), and *Alcohol/Drug Addiction* (82.2%). Approximately half of the participants were likely to refer church members with *Anxiety* (57.5%), *Marital Relationship* (55.7%), *Anger* (64.4%), *Parenting* (54.0%), *and Adjusting to Life* (48.3%) problems. Respondents were least likely to refer church members for issues relating to *Racism/Discrimination* (32.8%), *Finances* (32.3%), and *Work* (28.2%).

Each of these issues was analyzed by race/ethnicity to explore significant cultural differences. Five of the thirteen categories revealed statistically significant differences. Response category “Maybe”, was not included in the subsequent Figures.

As indicated in Figure 9, Caucasian (67%) and Hispanic/Latino (46.2%) clergy were significantly more likely to refer a congregant to a mental health professional who was experiencing marital problems, while only one-fourth (27.3%) of African-American clergy would definitely make a referral.

Figure 9

I would be likely to refer church members to a mental health professional (counselor) if they have trouble in a marital relationship.

	Yes	No
Race* **	**%**	**%**
African-American	**27.3**	**40.9**
Caucasian	**67.0**	**6.1**
Hispanic/Latino	**46.2**	**19.2**

Note: ***p>.000

Similar findings were found regarding depressive disorders. Approximately 89.6% of Caucasian clergy and 85.2% of Hispanic/Latino clergy stated they would be likely to refer a church member with depression to a mental health professional, while only 54.5% of African-American clergy stated they would refer (Figure 10).

Figure 10

I would be likely to refer church members to a mental health professional (counselor) if they have problems with depression.

	Yes	No
Race*	**%**	**%**
African-American	**54.5**	**9.1**
Caucasian	**89.6**	**1.7**
Hispanic/Latino	**85.2**	**0.0**

Note: *p >.005

Moreover, when asked if they would be likely to refer congregants experiencing problems with racism and discrimination, Hispanic/Latino clergy (57.7%) were significantly more likely than African-American or Caucasian clergy to make the referral (Figure 11).

Figure 11

I would be likely to refer church members to a mental health professional (counselor) if they have problems with racism and discrimination.

	Yes	No
Race**	**%**	**%**
African-American	**13.6**	**50.0**
Caucasian	**32.5**	**17.5**
Hispanic/Latino	**57.7**	**11.5**

Note: **p> .001

Preferences for Referral Relationships

The next section of the survey explored the pastors' willingness to consult, collaborate, or refer congregants with problems to mental health professionals. Responses were analyzed according to ethnicity in order to determine whether referral preferences vary among different ethnic or racial groups.

As indicated in Figure 12, African-American (90.8) and Hispanic (81.5) respondents were significantly more likely to *Agree* or *Strongly Agree* that their congregants were usually more comfortable receiving pastoral counseling rather than going to a mental health professional.

Figure 12

I believe church members usually feel more comfortable receiving pastoral counseling than going to a mental health professional (N = 172)

	Agree	Strongly Agree
	%	**%**
Race**		
African-American	**54.5**	**36.4**
Caucasian	**50.0**	**4.4**
Hispanic/Latino	**55.6**	**25.9**

Note: **p > .001

Approximately 58.1% or clergy respondents indicated that it was *Very Unlikely* that their role as a pastor or leader would be compromised or devalued by the involvement of a mental health professional within the congregation. However, 25% of Hispanic clergy felt that it was

Likely or *Very Likely* that their role as a minister would be compromised by a mental health professional's involvement within the congregation (Figure 13).

Figure 13

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.

	Likely	Very Likely
Race**	**%**	**%**
African-American	**0.0**	**4.8**
Caucasian	**0.9**	**1.7**
Hispanic/Latino	**21.4**	**3.6**

Note: **p > .001

In addition, approximately 50% of African-American clergy and 48.1% or Hispanic/Latino clergy reported that they would be *Likely* or *Very Likely* to prefer consulting with a mental health professional of the same ethnicity, while only 1.7% of Caucasian respondents indicated that they would prefer consulting with someone of the same ethnicity (Figure 14).

Figure 14

I would prefer consulting with a mental health professional who is the same race or ethnicity as me.

	Likely	Very Likely
Race***	**%**	**%**
African-American	**20.0**	**30.0**
Caucasian	**1.7**	**0.0**
Hispanic/Latino	**25.9**	**22.2**

Note: ***p > .000

Clergy were also asked if they would prefer referring a church member to someone from their own religious denomination. Table 15 indicates that, compared to Caucasian pastors, African-American pastors (15%) and Hispanic/Latino clergy (34.6%) were significantly more likely to prefer referring a church member to a professional counselor who was from their same denomination. Conversely, only 8.7% of Caucasian clergy indicated that the religious affiliation of the counselor was *Important* when making a referral.

Table 15

If you were to refer someone to a professional counselor for substance abuse or mental health challenges, how important is it that the counselor is from the same denomination as your church?

	Important	Very Important
Race* **	**%**	**%**
African-American	**15.0**	**0.0**
Caucasian	**8.7**	**0.0**
Hispanic/Latino	**19.2**	**15.4**

Note: ***p > .000

Referral Patterns

The number of referrals made by clergy to mental health agencies was measured within a six month period. Numeric responses were condensed into three categories: 0 persons, 1-5 persons, and 6 or more persons.

Figure 10

In the past six months, approximately how many people have you referred to a local mental health counselor or counseling center?

	0 Persons	1-5 Persons	6+ Persons
Race **	**%**	**%**	**%**
African-American	**31.8**	**45.5**	**22.7**
Caucasian	**20.7**	**55.2**	**24.1**
Hispanic/Latino	**64.3**	**14.3**	**21.4**

Note: **p>.001

Of the respondents, approximately 77% reported referring fewer than five people within the past six months. Hispanic clergy referred significantly fewer individuals with over 64% reporting making no referrals within the six months prior to completion of the survey.

Discussion

Because clergy are often on the front lines when individuals and their families are dealing with a mental health crisis, it is encouraging to see that the strong majority of clergy believed they could recognize such a crisis. They also generally understood that church members often prefer their help and support more than the formal mental health community, often due to issues of trust, stigma, and finances.

Marriage/family problems, mental health challenges, and substance abuse challenges were the most common issues among church members, while violence and sexual abuse were encountered by ministers less frequently. Compared to Caucasian and Hispanic clergy, African American pastors were significantly more likely to encounter substance abuse problems on an almost daily basis. However, both African American and Hispanic/Latino clergy encountered issues of family or community violence significantly more often than Caucasian clergy. 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 than in Caucasian communities.

Between 80-90% of ministers were likely to make a referral for depression, nervous breakdowns, domestic violence, sexual abuse, and alcohol/drug addiction. Approximately half of the participants were likely to refer church members with anxiety, marital relationships, anger, parenting, and adjusting to life problems. Less than one-third were likely to refer church members for issues relating to racism/discrimination, finances, and work-related issues.

African American clergy were significantly *less* likely than Hispanic/Latino or Caucasian clergy to make referrals to mental health professionals for marital difficulties or depression. Hispanic/Latino clergy were significantly *more* likely to make referrals to mental health professionals if their congregants were having problems with racism or discrimination, financial difficulties, or problems at work. These ethnic referral preferences possibly reflect cultural biases surrounding the use of mental health services.

Most pastors 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. The respondents' willingness to refer for issues relating to anxiety, marital relationships, anger, parenting, and adjustment to life problems dropped approximately 50%. These problems were potentially regarded as less serious in nature by clergy. Issues of racism/discrimination, financial difficulties, or problems at work, were also least likely to be referred for counseling, once again reflecting clergy willingness to handle these issues independently.

A majority of respondents expressed willingness to consult with a mental health professional about church members' mental health issues, particularly if the circumstances were judged to be beyond their knowledge or expertise. Consistent with these opinions, almost none of the clergy felt their role would be devalued or compromised by the involvement of a mental health professional in their church.

While almost three-fourths of clergy did not feel a need to consult with a mental health professional of the same ethnicity, there were several notable exceptions. While almost no Caucasian clergy expressed this preference, almost half of Hispanic/Latino and African American clergy preferred consulting with someone of similar race or ethnicity. This finding is consistent with prior studies in this area and likely reflects concerns by pastors 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.

In addition, clergy from ethnic minority groups were more likely to prefer consulting with a mental health professional of their own religious denomination. Compared to Caucasian clergy, African American pastors were twice as likely, and Hispanic/Latino pastors were more than four times as likely, to prefer referring a church member to a professional counselor who was from

their own denomination. The desire for a counselor who understood the church members' doctrinal beliefs may have played some role in this preference. Such findings highlight the importance of developing a network of culturally competent referral sources to which minority pastors can comfortably send their church members. This may require that professionals in the mental health and substance abuse community develop a resource list and begin the process of networking pastors with those culturally competent professionals.

When asked to state the number of referrals they had made to a mental health counselor or agency within the past six months, less than one-third had not made any mental health referrals. However, almost half of the pastors reported making 1-5 mental health referrals and one-third had made 1-5 substance abuse referrals in the past six months. As indicated previously, the majority of clergy expressed willingness to consult and even collaborate with mental health professionals, both within and outside of their churches. These findings show that pastors are generally open to working with counselors and find value in their training and expertise. This openness provides an important opportunity for clergy and professional counselors to collaborate in educating and assisting church members with mental health and substance abuse challenges. Opportunities for such partnerships may be more likely and achievable than either group thought possible, particularly if consideration is given to the cultural context of the churches.

Because respondents were not asked to estimate the total number of church members they encountered with serious mental health issues in the past six months it is difficult to tell whether they are referring some, most, or all of these individuals to a mental health agency or professional. However, it is important for pastors 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 who are known, trusted, and competent would likely increase the levels of referrals and lower the stigma associated with mental illness among congregants. Improving these collaborative relationships could help to ensure that persons with mental health challenges receive the help they need from a service provider that values their faith and provides appropriate treatment.

Limitations

While the results of this study provide valuable insight into the attitudes and perceptions of clergy in Kent County, Michigan, the sampling frame of one Midwestern region limits the generalizability of the findings. In addition, the modest response rate from self-selected clergy and higher response rate from local Dutch Reform church could create a potential sampling response bias.

Conclusion

Traditionally, clergy have acted as a major resource for their congregants, with a long history of meeting the social and emotional needs of their communities. Many churches not only provide resources to their parishioners and community members but also serve as a gateway to other services offered by the larger community. As a bridge to services, clergy can play a key role in connecting members to mental health and substance abuse services (Chalfant et al., 1990).

Initial research has found some evidence that pastors are concerned with the mental health needs of their church members and are willing to collaborate with mental health professionals to help address these needs (Neighbors et al., 1999). One important way churches can collaborate with the mental health and substance abuse communities is by providing a culturally competent context in which services can be offered. Some congregants are suspicious of mental health

professionals, resulting in the underutilization of services (US Department of Health and Human Services, 2001). Providing 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).

Mental health professionals must continue to look for ways to increase the utilization of mental health services within the religious community, specifically among ethnic minorities. By providing additional training in mental health education and collaboration, treatment providers can strengthen connections with religious leaders, particularly among less educated and minority clergy. Collaboration with clergy is one way to remove some of the existing barriers to mental health services and to increase culturally competent service options.

References

Bohnert, A., Perron, B., Jarman, C., Vaughn, M., Chatters, L., Taylor, R. J. (2010). Use of Clergy Services Among Individuals Seeking Treatment for Alcohol Use Problems. *The American Journal on Addictions, 19* (4) 345-351.

Chalfant, H.P., Heller, P.L., Roberts, A. (1990) The Clergy as a Resource for Those Encountering Psychological Distress. *Review of Religious Research, 31*(3) 305–313.

Chaves, M., Anderson, S. (2006) Continuity and Change in American Congregations: Introducing the Second Wave of the National Congregations Study. *Sociology of Religion, 69* (4) 415-440.

Crowe, A. H., & Bilchik, S. (1998). Drug identification and testing summary. Retrieved August 15, 2010, from: http://ojjdp.ncjrs.gov/PUBS/drugid/contents.html.

Hernandez, E.I., Carlson, N., Medeiros-Ward, N., Stek, A., Verspoor, L. (2008) *Gatherings of Hope: How Religious Congregations Contribute to the Quality of Life in Kent County.* Grand Rapids, MI: Calvin College Center for Social Research.

Kessler, R. C., Nelson, C. B., McKinagle, K. A., Edlund, M. J., Frank, R. G., & Leaf, P. J. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry, 66*(1) 17–31.

Kessler R.C., Chiu W.T., Demler O., Walters E. E. (2005) Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*. *62* (7) 617-27.

Murray, C. J., & Lopez, A. D. (Eds.). (1996). *The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020.* Cambridge, MA: Harvard University Press.

National Institute of Mental Health (2009) The Numbers Count: Mental Disorders in America. *National Institutes of Health.*
Retrieved August 15, 2010 from: http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml#Intro.

Neighbors, H. (1985) Seeking Professional Help for Personal Problems: Black Americans' Use of Health and Mental Health Services. *Community Mental Health Journal, 21*(3) 156-166.

Neighbors, H., Caldwell, C., Williams, D. Nesse, R., Taylor, R., Bullard, K. (2006) Race, Ethnicity, and the Use of Services for Mental Disorders: Results from the National Survey of American Life. *Archives of General Psychiatry, 64* (4) 485-494.

Pickett-Schenk, S. A. (2002) Church-based support groups for African-American families coping with mental illness: outreach and outcomes. *Psychosocial Rehabilitation Journal, 26* (2) 173–180.

RachBeisel, J., Scott, J., Dixon, L. (1999) Co-occurring severe mental illness and substance use disorders: A review of recent research. *Psychiatric Services, 50* (2) 1427–1434.

Regier, D. A., Narrow, W. E., Rae, D. S., Manderscheid, R. W., Locke, B. Z., & Goodwin, F. K. (1993). The de facto US mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry, 5* (2) 85–94.

Rice, D. P., & Miller, L. S. (1996). The economic burden of schizophrenia: Conceptual and methodological issues, and cost estimates. In M. Moscarelli, A. Rupp, & N. Sartorious (Eds.), *Handbook of mental health economics and health policy. Vol. 1: Schizophrenia* (pp. 321–324). New York: John Wiley and Sons.

Substance Abuse and Mental Health Services Administration. (2009). Results from the 2008 National Survey on Drug Use and Health. Rockville, MD: Department of Health and Human Services, Office of Applied Studies.

Taylor, R.J., Ellison, C.G., Chatters, L.M., Levin, J., Lincoln, K. (2000) Mental Health Services in Faith Communities: The Role of Clergy in Black Churches. *Social Work, 45* (1) 73-87.

U.S. Department of Health and Human Services. (2000). Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

U.S. Department of Health and Human Services. (2001). Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Wang, P.S., Berglund, P. A., Kessler, R.C. (2003) Patterns and Correlates of Contacting Clergy for Mental Disorders in the United States. *Health Services Research, 38* (2) 647-673.

WHO World Mental Health Survey Consortium (2004) Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization. *American Medical Association, 291* (21) 2581-2590.