



Connections

— for communities that care

CHURCH CHAT

CLERGY AS GATEKEEPERS TO MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

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Connections wishes to express deep gratitude to all who made this article possible! One of the most important connections in wellness is the spiritual connection. This article makes significant progress in both understanding the importance and in providing guidance as to how we can strengthen our networks that address this desire for spiritual support. We acknowledge that this research focused on Christian clergy and therefore we must recognize the limitations in transposing the findings to other spiritual traditions; however, it in no way diminishes the significance of spirituality in other faiths. If anything, it prods us to replicate this research.

—Clint Galloway, Editor

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 et al., 2003). A recent study indicated that approximately 39% of Americans seek counseling services from clergy (Taylor, et al., 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 church member, have less stigma, offer free services, are credible, and may frame the problem in spiritual terms that are more comfortable for the client (Bohnert et al., 2010).

However, it is important for clergy to be aware of their limits and make referrals to trained mental health professionals when necessary. As such, clergy often serve as gatekeepers to the provision of professional mental health and substance abuse services. 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, particularly within the African American community (Clansy, 1998). Research 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.

In June 2009, the Doug and Maria DeVos Foundation contracted with the Center for Community Impact Research at Andrews University to evaluate various aspects of a project designed to connect church members to mental health services (this project will be reported in another edition of *Connections: Communities That Care*). One aspect of the project was to conduct a 57-item survey of all known pastors in Kent County, Michigan. Using an e-mail contact list of pastors developed by the DeVos Family Foundations (Hernandez et al., 2008), 215 pastors from over 50 Christian denominations

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responded to an online survey. Respondents were most likely to be male (88%), over 50 years old (59%), well-educated (72% had a master's degree or above), with 75% having served for 11 or more years in ministry. Pastors' ethnicities roughly reflected the county population (67% White, 16% Hispanic/Latino, and 12% Black). This report briefly summarizes findings from that survey regarding knowledge and beliefs about mental health issues, frequency of clergy encounters with congregants who were experiencing mental health or substance abuse challenges, willingness of clergy to refer congregants to or work with mental health and substance abuse professionals, and referrals they have made when faced with such challenges.

Knowledge and Beliefs about Mental Health Issues

Table 1 shows that a large majority of clergy believe they can recognize a serious mental health crisis. They also generally understand that church members often prefer clergy help and support more than the formal mental health community. Most clergy favor a biological or physical explanation for serious mental illness. As such, they are generally supportive of medication usage and do not think church members are imagining their symptoms or lacking in faith. As noted in a later section, this recognition often translates into a referral to a mental health professional when the issue becomes serious.

Over a third of clergy believe that individuals experiencing serious mental health challenges could be possessed by demons. While this is not an unexpected finding for pastors who think about peoples' problems in spiritual terms, it may highlight an area where further education could help pastors better understand the complex factors involved in mental illness, particularly for those conditions that can trigger psychotic thoughts and behaviors. It may be helpful for pastors to understand the role that medications can play in managing a brain disease 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.

TABLE 1

	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 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%
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 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 church members usually feel more comfortable receiving pastoral counseling than going to a mental health professional	2.3%	9.9%	24.6%	50.9%	12.3%

Frequency of Clergy Encounters with Mental Health or Substance Abuse Challenges

As seen in Table 2, pastors regularly encounter serious and challenging issues. Reports of substance abuse and violence are more prevalent within minority communities. Such differences are more often seen within communities that experience

higher levels of economic challenges, a phenomenon more common within African American and Hispanic communities than in Caucasian communities.

TABLE 2

	Almost Never	A Few Times a Year	Monthly	Weekly	Almost Everyday
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%

In conjunction with well-trained and culturally competent professionals, it may be helpful for pastors to develop brief pulpit presentations on key topics such as stigma, signs and symptoms of a mental illness, or how to help someone

with a drug problem. Pastors could also invite mental health professionals to their churches to present more detailed training seminars relating to mental health and substance abuse challenges commonly seen in their churches.

Willingness of Clergy to Make Referrals

Between 80-90% of pastors are likely to make referrals for issues that they view as more serious in nature, such as depression, nervous breakdowns, domestic violence, sexual abuse, and alcohol/drug addiction (no table provided). They likely recognize these issues as often being beyond their scope of training and expertise and are 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 likely 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, are least likely to be referred for counseling (less than one-third), possibly again reflecting clergy willingness to comfortably handle these issues on their own.

Clergy Preferences for Consulting, Collaborating, and Making Referrals

As seen in Table 3, the majority of clergy express willingness to consult and even collaborate with mental health professionals, both within and outside of their churches. Most clergy are willing to allow mental health professionals to present seminars or lead in support groups in their churches, with around one-half willing to collaborate on community service out-

TABLE 3

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	Not Likely at All	Unlikely	Not Sure	Likely	Very Likely
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 would allow a mental health professional to have an office in my church	9.4%	12.3%	26.9%	26.3%	25.1%
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%
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%

Paper, a Pencil, and a Meaningful Partnership

By Traci Flaughter, Make a Difference Partner, Hope Network

It's selfish really. You go to work thinking, "I'm going to help and teach others," but a lot of times you end up learning more yourself.

I've been working for Hope Network for over three years now, most of that time here at the Cedar Springs Center. Our center provides skill development and paid work opportunities, as well as community integration and support services, for people with developmental disabilities. It's not what I planned on doing with my life.

When I was in college, I needed a job. There was a large residential facility that was always hiring, so I started working third shift there. I had no idea, of course, that changing bedding was going to change my life. I think it was the first time in my life that I got it—really got it—that my actions could make a difference in another person's life. It wasn't that I did anything great, it was just that through something as simple as consistency on my part, another person was able to make strides toward independence; able to exceed their expected potential.

I think working in this field offers unlimited opportunity for personal growth. My experiences with my *Make A Difference* partner, Deb Smith, have proven this again. *Make a Difference* is a program that connects employees and consumers across Hope Network Developmental and Community Services in a series of group activities and learning circles. Led by Hope Network staff, *Make a Difference* provides a framework for dozens of individuals to build meaningful relationships and achieve their goals and dreams together, whatever those may be.

Deb is a kind, confident woman who has long dreamt of being a writer. She wanted to focus on that dream, so we found a writing group at a local church. It was a great connection, and not just for Deb. Throughout the process, I saw Deb really grow as a writer. Now she not only works on her stories, but writes poetry as well. Her focus has improved and she has been able to write more descriptively. Her confidence has increased at work as well. She is trying new jobs and leading group activities.

"You helped me figure out what I wanted to do for a living," Deb shared with me as she sat in the break room at Cedar Springs Center, notebook in hand. "I learned that I can work

here and write a book on the side."

Deb always talks about how doors open for us at the right time. *Make A Difference* was a double door that Deb and I walked through together. In high school and college I was always involved in some creative endeavor, writing or art classes. At the time I started working with Deb, I had been neglecting that aspect of my life. I was a little surprised at the first writing group that we went to, when I realized I was expected to write as well. So, with Deb's help, I rediscovered my own passion for writing, and like Deb, I also participate in a regular writing group.

Funny that I happened to be a partner with someone who could show me a thing or two. And not just any old thing or two, but the very things I needed to learn, the very things I needed to push me in the right direction, the very things I needed to grow. This is the work that most people consider a service or a sacrifice. They say it takes a "very special kind of person" to do this kind of work.

Odd then, isn't it, that this is where I am taught to grow, where I learn the most, and where I receive the greatest gifts?

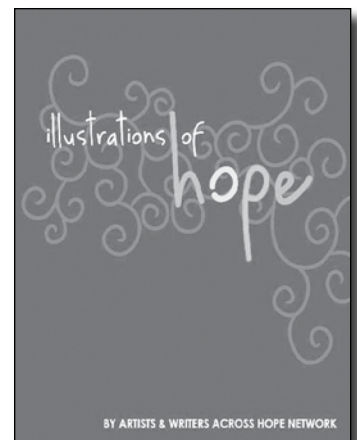
Recently, our works were published in *Illustrations of Hope*, a collection of works from individuals across Hope Network. To learn more about *Illustrations of Hope* or the Make a Difference program, visit www.hopenetwork.org/MakeADifference. ■

About Hope Network

Hope Network is a non-profit Christian organization founded in 1963 to empower people with disabilities or disadvantages to achieve their highest level of independence. We provide a continuum of specialized care for those with brain and spinal cord injuries, mental illness, developmental disabilities, substance use disorders, and other disadvantages. Our support services include transportation, subsidized housing, and workforce development.



Deb Smith (left) and Traci Flaughter



Clarissa

An Interview with Connections Editor, Clint Galloway

Within the first two minutes of my interview with Clarissa it seemed as though I was sitting down with an old friend I hadn't seen for some time and chatting about life. Her lilting voice revealed a deep enthusiasm to share her story with others that they might capture the hope of living a life as full as hers has become. She was so at ease, and the words simply flowed, filled with exceptional wisdom earned in the battles with substance use. Our conversation began with Clarissa talking about her children, the heart and soul of her life. They were home from school due to illness. "The doctor told me," Clarissa chimed, "if there is anything to catch, they will catch it." Our conversing continued without any distraction from all the obvious activity surrounding Clarissa. The children were simply an extension of her presence.

Connections: Clarissa, I had the good fortune to read the story of your struggles with substance use which you shared two years ago in a publication by Sacred Heart Rehabilitation Center. It is a moving story of recovery. Your story communicates what it is that heals. (Clarissa and her family were residents of Clearview, a specialty women's and children's residential service, located in Port Huron, administered by SHRC.)

Clarissa: Oh I think that is so important to tell our stories. Just yesterday I was telling a friend of mine that I would love to tell you my story. Perhaps it will help us get the help we need, so I am so grateful to be able to share my story with you. This is something that I really like to do. That is why I go to speak at Clearview, and I let the ladies know that their lives can change, too. I think it's so important that we no longer hide in the dark.

C: I've especially wanted to talk with you, Clarissa, because I've had trouble getting someone to speak of their problems with substance use, and many individuals with mental illness also struggle with this.

Clarissa: Yes, it's typical of people with mental health issues to try and medicate themselves with the street drugs and things like that.

C: So let's talk about the children; how old is your oldest child now?

Clarissa: My oldest, Gary, is 11; then my daughter, Amanda,

is 9; and my youngest, Xavier, is 7.

C: And how have they been doing?

Clarissa: You know, they've been doing fine; they've really blossomed. In the three years that I've been in recovery, I can see a definite change in them. I was just talking about my youngest one at a meeting today.

He just got a report card, and it was the first time he

just got a terrible report card. And the teacher had been telling me that he had perhaps had an attention deficit problem and that perhaps we should treat it with medicine.

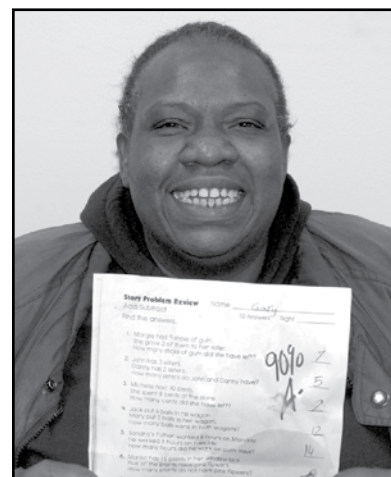
Up to this time I've been able to say, "Look, Xavier, I just want you to go to school, and I want you to focus, and I want you to work really hard," and that was it. But it's getting harder and harder for him to focus now and I need to get some help. I really want to avoid the medication thing if I can. You have no idea, Clint, how many times I've been in these meetings and I'll listen to young people, and they say that the first drugs they got high on were their ADD medications. And that troubles me a lot. So I'm looking at other ways to avoid getting them on medication.

My two oldest ones are on the honor roll. They are doing very, very well. They have good behavior and my oldest son is quite proud of being on the safety patrol and he is also on the student council. He ran for president but he didn't win but he's cool with that. I said, "OK, baby, that's just a small step...you will take larger steps later on, and one day you will be president of the United States and then you'll look back and see this as just the one election you lost." [Clarissa engages in one of her many infectious laughs] Yes, they're a really good flock! I can see the progress in my recovery in them, I really can.

C: So tell me about how you have been doing.

Clarissa: Oh, there are a number of things. There's been progress in my life. I've got my GED. And I've been to college, and I've actually received my certification in medical

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Clarissa, proud mom!

"I can see the progress of my recovery in them, I really can!"

Clarissa (from page 5)

billing and coding, and I want to go back to school to eventually receive a degree in health management. Right now I've been able to keep up with my community service talking with persons, and I regularly attend AA meetings and do a lot of volunteer work at the children's school.

C: So you've been busy!

Clarissa: I try to keep busy, I really do.

C: Do you anticipate acquiring a job in medical billing?

Clarissa: Oh yes, yes! It's just a matter of time. What I run into now, most of the time, is that people want experience. But I truly believe that there is a need for me out there somewhere, I just have to keep at it; just have to keep working, and that's what I'm currently doing. I'm putting my resume out on the Internet and I'm registered with a couple job sites, so something's going to happen, I'm confident of that, it's just a matter of time. [Her voice exuding hope.]

C: So you have access to the Internet?

Clarissa: Yes, I usually go down to Michigan Works and use their computer and internet, we don't have a computer yet. That's something we're working on.

C: You've been doing a lot in the past two years! What would you say has given you the most joy?

Clarissa: [brief hesitation] I think probably my education, because it benefits everybody—not only me—but the children and the people around me. That has brought me the most joy and a sense of accomplishment. It was never a matter that I didn't have people pushing me to get an education when I was younger, but I just lacked the motivation because I started using drugs really young. And that's the problem with young people using drugs, it takes away their motivation.

C: No doubt, as we progress as you have, our dreams grow and change; what are your dreams now?

Clarissa: You know it's funny, but one of my favorite dreams is homeownership, I really want my own home. I think that will give me a great sense of security. Where I am at right now is great but I think so much more comes along with owning your own home, and that's one of my goals in the next five years—to own my own home, and perhaps to even have my own business.

C: That's great! Do you still visit Clearview?



Clarissa: Yes, in fact I live in the Sacred Heart supported housing, and I frequently go back to give the open talks to the ladies in treatment.

C: Then you continue to find support from the ladies at Clearview?

Clarissa: Oh yes! The ladies I see there have been so supportive with everything from the moment I got out. If I have an issue or problem, there is always someone there that I can go and talk to if I need to. They're so supportive. You know we've moved quite a ways away from Clearview and the school bus brings the oldest two children home. And for the first couple of months after moving here, I would be sitting at home wondering, "Where are the kids?" And I would get a phone call, or someone would be knocking on my door, and it would be someone from Clearview with the kids. You know we were there so

long. It was the first stable home we ever had, and they still love to go over there. The school the kids go to is right across from Clearview. If I have to go over there to give some open talks while they're in school, they just come over there when school's out. They still love it. I've never had support in my life quite like that.

C: I suspect that the key to successful recovery is the opportunity to establish some supportive relationships, and it appears the ladies at Clearview provided just that.

Clarissa: Oh definitely! And from the moment I got out, I immersed myself in the Narcotics Anonymous groups that are around town, and they really helped me and the kids get rooted in the community because we weren't from here. And I started bonding with quite a few people in the community. It was kind of hard at first, but they really helped me make friends. They've given wonderful support for me and the kids. The kids played with kids whose parents were in the program, and they would spend the night with them. It's really been important. That's been a large part of my recovery; I've found people I can support, and they support me.

C: In the Sacred Heart article you were asked what advice you might offer to people who are struggling with similar problems and you replied, "Find a higher power that can open your heart and mind." Do you have any suggestions for people that might find this difficult?

Clarissa: Oh, yes. I know a person who is having a problem with higher powers and spirituality and things like that, and I often tell her that if you don't have faith, then guess what,

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A Community's Model for the Future

The Livingston Recovery Oriented System of Care Access Center

Kathy A. Polasky-Dettling, MA, LLP, Program Director, Access Services, Livingston CMHSP, with Marci Scalera

Things alter for the worst spontaneously, if they be not altered for the better designedly – Francis Bacon

Previous issues of *Connections* have included 17 articles focusing on the principles of recovery (four of them authored by Greg Paffhouse) which have addressed the history and development of the concept, with special attention to the Michigan creation of the Recovery Council. The remaining 13 articles have been first person stories by peer support specialists who serve on this council. In this article, we initiate a series that describes models of delivering services that are congruent with the principles of recovery. We begin with access. Please note that the authors identify the similarity between recovery-oriented principles and those of community-based treatment that have been transforming our system. It's not the label that makes the difference, it's the principles. –Editor

Most people can readily embrace change if there is recognizable value in it. So many of the changes we experienced in the mental health field over the past forty years have had value: better understanding of mental illness, de-institutionalization, the newer medications, peer services, and best practices. Change doesn't mean the way we used to do this was wrong or not valuable, but that new ways of doing things might give us better outcomes, are more cost efficient, and be closer to what our community is requesting.

In the 1980's, there was an unwritten rule that people with substance abuse disorders had to be clean and sober for 60 days before being assessed for community mental health services. There were, of course, the exceptions: if a person ended up in a psychiatric facility or jail, if the person disclosed substance abuse issues after beginning treatment, or if the person came to the attention of the community.

In retrospect, I have no recall of learning this rule in my college master's program or ever seeing it in a policy and procedure manual, but it seemed to be a "rule" for most Access providers. The "rule" faded as our CMHSP experienced more "exceptions" and we began to learn more about co-occurring disorders, and with this new welcoming approach came hope for recovery.

For the Livingston CMHSP Access Center, it was an ongoing battle to assure that people were getting the right services to meet their needs. Many of the people calling or walking in for services would disclose significant substance dependency issues along with complex care needs. Giving people

the phone number to the Livingston/Washtenaw Substance Abuse Coordinating Agency (CA) Access provider located in Ypsilanti didn't resolve the crisis, as it was one more call for a person to make, and the person's "story" would have to be told again, and the result might be a referral back to the CMH.

Over the years, Livingston CMHSP and the CA enjoyed a very positive and collaborative relationship. The two agencies were partners in co-occurring grant opportunities and were involved in community groups dedicated to improving access to substance abuse and mental health services. The agencies collaborated on complex care cases on a regular basis. However, having two access points for people with



"Access staff are able to say yes to most everyone asking for help, and are also able to get people the right service in the right amount with very little wait time, or hoops to jump through," says Angela Willoughby, Program Coordinator of Access Services. Angela is seated. Standing is Kathy Polasky-Dettling, Program Director of Access Services.

very similar and complex needs didn't make sense to the Livingston community since the majority of service requests came to the CMHSP because they had daily walk-in

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A Community Model (from page 7)

services along with after-hours emergency services.

In 2008, Livingston CMHSP was experiencing what most other CMHSPs were: reductions in general funds and an overall increase in requests for services for people without Medicaid. The cost of maintaining the Access Center was very high and a reduction in staffing was likely due to the cuts. The Access Center was responsible for screenings, eligibility assessments, emergency services, and hospital, court and jail liaison services—all the entry points to a CMHSP. The Coordinating Agency would also provide assessments at the jail and the courts and often times, both agencies would assess the same people.

At this point, Livingston CMHSP was approached by the Coordinating Agency to take over the Substance Abuse Access responsibilities. The Livingston CMHSP Board decided to embrace this vision of the organization as a multi-functional, multiple population manager, and provider of services. The SA Access responsibilities were added to the Access Center without adding on any additional staffing or other costs. The CA provided ongoing training and consultation to help the Access staff navigate the complex world of substance abuse funding, confidentiality rules and level of care decision making. The overall cost of providing an Access Center decreased and the funding provided by the CA offset the general funds cuts.

For the first time in the Livingston community, people calling or walking in for services only had to provide their demographic information and “story” once to access services, and there was one electronic medical record that could be accessed by both the substance abuse and mental health providers to assure non-duplication of services. People involved in the court system and in jail received one assessment. The CA also provided funding for a half time case manager to assist with people with complex care needs. Within six months, access to substance abuse services increased by 25 percent.

In FY 2010, the CA began providing information about a new way of working with people with substance abuse disorders called Recovery Oriented Systems of Care (ROSC). The ROSC premise is that people achieve recovery from their substance abuse disorders when the treatment approach is community-based, and involves peer support in helping to meet basic needs. The ROSC transformation model is highly reminiscent of the CMHSP transformation model of community based treatment, and was a movement from a medical model to a more holistic and recovery oriented model. The Access Center began utilizing ROSC principles, which resulted in a decreased use of more costly out of county services, and the CA was able to fund pilot programs that

included engagement groups, peer supports and case management.

For FY 2011, Livingston CMHSP’s role expanded to include full management of the substance abuse treatment dollars for the county. The administrative and clinical functions that were a part of this set of expanded responsibilities were absorbed without adding any additional cost to the CMHSP. The Livingston CMHSP electronic medical record and claims management system was utilized to handle the encounters and data submissions requirements at no additional cost.

The FY 2011 Access model now consists of daytime routine access, and nighttime emergency access to mental health and substance abuse treatment services. The majority of people seen through Access have complex care needs that can be met either through the mental health or substance abuse provider network. The same comprehensive needs assessment is completed, and based on Minkoff’s Four-Quadrant Model, the person requesting services is assigned a provider in either the mental health system or in the substance abuse system that is co-occurring capable and has case management and peer supports as primary components.

The Livingston community has expressed their satisfaction with the access process, and very few people leave the Access Center without a set appointment for treatment and a solid intervention plan. The CA continues to provide ongoing consultation and access to grant funding, but the overall cost has been reduced to one FTE for both Washtenaw and Livingston Counties, thus resulting in a significant decrease in administrative costs. It was a change that the community embraced because it added value, improved outcomes and resulted in a process that can be sustained financially. ■

No-cost COD (Co-Occurring Disorders)

Resources for viewing, downloading and/or ordering from the web are available on the MACMHB web site.

Select “NO COST COD RESOURCES” (left hand column under “SERVICES”) on the home page.

Also available on the home page is the 2011 Calendar in PDF format, and a listing of scheduled conferences and trainings from spring through fall.

www.macmhb.org

In 2006, network180 (formerly known as Kent County CMH) contracted with Earl James to gain input from persons in Kent County who were eligible for mental health and substance use disorder services but were not using network180 services. James was the executive director of City Vision, Inc., a church and community consulting organization in Grand Rapids, Michigan, and a member of the De-Vos Urban Leadership Initiative. (More recently, James was appointed by the Reformed Church in America as its first Coordinator of Multiracial Initiatives and Social Justice.)

James clearly brought the needed skills to acquire the information we desired. He gathered information from 45 individuals, including members of the African American, Hispanic American, Native American, Asian American, and faith communities. The primary conclusion of this study was that network180, a government institution, was not trusted by these communities. While many individuals recognized their need for services, they were afraid of the potential negative consequences that might occur to them or their families as a result of interacting with a governmental body. Network180 did not have relationships with trusted, grass roots organizations in these communities. James made the following recommendations:

- Form a task force composed of members of this unserved community to acquire their advice on how to address this situation.
- Establish relationships with trusted grass roots organizations in these communities.
- Find ways to involve the faith community in this conversation.
- Increase the diversity of our professional therapists.
- Increase our marketing efforts to reach out to underserved communities.
- Expand our prevention efforts with this population.

- Encourage communities of color and faith to develop agendas that demand access to mental health and substance use disorder services.

Some observers might be asking, “Why bother?” With increasing demands for services and reductions in general funds and substance use disorder funding, why would network180 expand its outreach to this underserved community and further increase demand for services?

Nevertheless, after consideration of these recommendations, the network180 board approved a strategic plan with specific goals around cultural competence and inclusiveness. These values shaped the policy, as well as the recognition that being proactive—serving needs before they escalated—could save money in the long run. They expected staff to:

- Assure equitable access to mental health and substance use disorder services to all members of our community. They identified community groups that were underserved including the Hispanic, refugee, African American, and Asian communities.
- Work with community partners to improve the effectiveness of treatment models to better serve these diverse populations.
- Increase the number of persons of color receiving mental health and substance use disorder services by making it easier for members of faith communities and their neighbors to access mental health and substance use disorder services.

Implementation of this strategic plan led to the development of “Project Get Connected,” designed to collaborate with African American pastors and congregations to address these goals. This project will be featured in a future issue of Connections. In June, 2009, the Center for Community Impact Research at Andrews University evaluated various aspects of this project, including a 57 item survey of pastors in Kent County. The findings of this survey are included in this issue in the article, “Church Chat.” ■



The Michigan Association of Community Mental Health Boards was created in 1967 to support county mental health services programs (CMHSPs) in promoting, maintaining and improving a comprehensive range of community-based mental health services, which enhance the quality of life, promote the emotional well-being, and contribute to healthy and secure communities which benefit all of Michigan's citizens. Services managed and delivered by CMHSPs are designed to assist individuals in achieving, maintaining and maximizing their potential and are provided in accordance with the principles of person centered planning.

reach 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 pastors are often suspicious of professional counselors and reluctant to collaborate with them, 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 ethnic/cultural context of the churches.

The role of ethnic background was found to be an important aspect of this study. While almost none of the Caucasian clergy feel a need to consult with a counselor of the same ethnic background, about half of all Hispanic/Latino and African American clergy prefer this opportunity. 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. This may also provide an ideal opportunity for pastors to learn about various aspects of mental health and substance abuse challenges.

Table 4 describes clergy willingness to make a mental health or substance abuse referral under several conditions. A very large majority of clergy from Evangelical, Reformed, and Pentecostal or Charismatic church traditions feel it is important to make a referral to a Christian mental health professional. This issue is substantially less important for mainline/other Protestant and Catholic/Orthodox clergy. This is an important concern for clergy and could possibly be addressed by developing a directory of licensed Christian counselors and counseling agencies within the county. Clergy may also wish to consider developing relationships with several Christian counselors who could offer educational presentations and consultations around key mental health and substance abuse issues.

TABLE 4

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%

While having a Christian counselor is viewed as important, a large majority of pastors consider a counselor’s denomination to be relatively unimportant. However, African American and Hispanic/Latino clergy are much more likely to consider this to be an important issue, again reflecting their desire to consult with a counselor who is culturally similar to their church members. The desire for a counselor who understands the church members’ doctrinal beliefs may play some role in this preference as well. Such findings highlight the importance of developing a network of culturally competent referral sources to which pastors of color 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.

As seen in Table 5, when clergy were asked how they would handle a church member with a serious mental health challenge, almost all pastors said they would be likely to make a referral to a mental health counselor. About two-thirds also said they would be likely to make a referral to a medical doctor, with less than half likely to make a referral to an emergency room. The variation in these responses, combined with one-third of clergy who were “not sure,” likely shows that pastors wish to consider the nature of the problem before deciding where to refer their church member. Very few of the pastors said that they would only offer prayer and spiritual counseling, likely indicating that most pastors 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 most clergy understand that the complexity of serious mental health challenges is best handled by professionals.

Finally, clergy were asked how many mental health and substance abuse referrals they had made in the past six months.

TABLE 5

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%

Less than one-third had not made any mental health referrals and less than one-half had not made any substance abuse referrals in the six months prior to taking the survey. 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. Since we did not ask pastors 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. 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 as pastors increase their understanding, support and referral of these church members. Improving these collaborative relationships would 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.

Conclusion

Many church members with mental health and substance abuse problems choose to talk with their clergy about the struggles they or their family members are facing. Clergy must be prepared to handle a wide range of complex issues since they often counsel with—and sometimes refer—persons with mental illness or substance abuse problems to appropriate treatment. They can improve their knowledge levels about these issues through further training. Such training can strengthen their abilities to appropriately help their church members. It can also broaden their professional networks and help them know when to make referrals to professionals who have more specialized training in areas of mental health and substance abuse. Through such improved training and networks, clergy can improve their abilities to support hurting church members; providing them with sensitive and appropriate care in times of crisis. ■

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(References concluded on back cover)



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Clarissa (from page 6)

you pray for faith and it'll come to you. It sounds weird, but it helps. I didn't have a lot of faith in the beginning, and that's what someone told me, "If you have no faith, then pray for it and eventually it'll come to you." That helped me a lot. And also, look at the small things that are working for you. For me it was a miracle that I was able to stay sober for a week, or even a day. And I knew that no one was doing that for me but God. I knew I wasn't capable of doing that for myself—not me, my family nor anyone. And so if anyone was having a problem with that, I would say just pray for faith and also have gratitude for the small things. It helps a whole lot when you're grateful.

C: *Clarissa, I find you to be an amazing woman; you have a lot of wisdom.*

Clarissa: Well thank you, Clint!

Editor: Like I said in the beginning, within a few moments it was like a reunion with a dear friend. We continued to chat and share stories for some time. For me it was reminiscent of sitting with those whose compassionate way of being in the world has sustained my faith in the basic goodness of humankind. Without this, it is doubtful if any of our efforts in healing will be successful.

I'm deeply indebted to Estee Weber at Sacred Heart Rehabilitation Center for connecting me with Clarissa. To acquire more information about Sacred Heart Rehabilitation Center, go to <http://www.sacredheartcenter.com>. ■

CHURCH CHAT (*references continued from page 11*)

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