

Referral by clergy who counsel older adults

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The purpose of this cross sectional study of clergy ($N = 493$) was to examine the likelihood of referral to formal mental health providers by those clergy who counsel older adults. Responding clergy completed a brief questionnaire that included information on the amount of counselling they do with older adults, the Attitudes towards Older Adults and Mental Illness (AOAMI) scale, their relationships with mental health professionals, their knowledge of resources for referring people for additional help, and basic demographic data, such as race, age, years in the clergy, and education level. In logistic regression analysis, respondents with more education, those who felt less prepared to provide counselling, and those with more positive attitudes based on the AOAMI indicated that they were more likely to refer, and no differences were found based on their denominational affiliation race, relationships with mental health professionals, or knowledge of resources for referring people for additional help. We believe that public-private partnerships should be formed to help clergy recognise when referrals are appropriate, and to help improve relationships between clergy and mental health professionals.

Keywords: clergy; counselling; mental health services; older adults; referral; mental health

As the baby boomer generation ages, they will need help to address numerous emotional and mental health issues such as depression (and sub-clinical depression), loss-related grief, adjustments to changes in health, chronic mental health conditions, and Alzheimer's disease and other dementias. Currently, a shortage of professionals trained specifically in working with the mental health needs of older adults exists, and this problem is anticipated to worsen as the population ages (Jeste et al., 1999; Kaufman, Scogin, Malone Beach, Baumhover, & McKendree-Smith, 2000). However, clergy¹ play a critical role in mental health service delivery by providing much counselling, often acting as gatekeepers to the formal mental health system, and being a major part of the *de facto* mental health system (Oppenheimer, Flannelly, & Weaver, 2004; Pickard, 2006; Wang, Berglund, & Kessler, 2003). For example, a classic 20-year study indicated that about 40% of Americans seek help from clergy when dealing with a personal problem (Veroff, Kulka, & Douvan, 1981), and of those attending religious services weekly, more than 50% considered their primary mental health service provider to be their religious leader (Larson, Milano, Weaver, & McCullough, 2000).

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Though it is impossible to know the exact number of clergy in the United States, estimates tend to be around 600,000 (Hartford Institute for Religion Research, 2006), up from the 353,000 reported in 1998 (US Department of Labor, 1998, 2010).

Several studies have concentrated on the relationship between clergy and mental health professionals (Benes, Walsh, McMinn, Dominguez, & Aikins, 2000; McMinn, Chaddock, Edwards, Lim, & Campbell, 1998; Moran et al., 2005; Oppenheimer et al., 2004). In general, these studies tend to agree that clergy are often the first source to whom people turn for help with mental health and emotional problems, that a need exists for more education and training for clergy, and that alliances between clergy and mental health providers can be beneficial to clients.

This is particularly true for African Americans. Possibly due to an historic mistrust of mental health treatment, African Americans are less likely to utilise professional mental health services than are non-Hispanic Whites (Wang et al., 2005; Wells, Klap, Koike, & Sherbourne, 2001), and African American clergy's counselling is known to function as a significant mental health service among African Americans (Chatters et al., 2010; Young, Griffith, & Williams, 2003). It is possible that the mistrust of the mental health system in general would lead to African American clergy making fewer referrals, but their education and experience may also affect their decisions on referrals. Whether differences exist between African American and Caucasian clergy remains uncertain, though, as we were unable to locate data on empirically known differences.

Although some attention has been given to clergy as being on the front line of the *de facto* mental health system (Larson et al., 2000; Pickard & Guo, 2008; Pickard & Tang, 2009; Wang et al., 2003), most research has been done on a general population rather than specifically with an older adult focus. In this study, we extend knowledge about collaborations between clergy and mental health professionals by examining what specific factors might be associated with the likelihood that clergy would actually refer older adults for further help. This knowledge has the potential to help us to better identify and address the mental health needs of older people.

The primary research question addressed by this exploratory study was: What factors are associated with the likelihood that clergy who counsel older adults for emotional problems will refer people for additional help from other formal sources?

Methods

Information for this study was gathered through the use of a parsimonious (two page) mailed survey using Dillman's Tailored Design Method (2000). The survey included information from the lead clergy person on the amount of counselling they do with older adults, the Attitudes towards Older Adults and Mental Illness (AOAMI) Scale, their relationships with mental health professionals, their knowledge of resources for referring people for additional help, and basic demographic data, such as race, age, years in the clergy, and education level. The study had approval from the Human Subjects Committee Institutional Review Board at the University of Missouri, St Louis. All information provided was kept strictly confidential, and respondents were anonymous; no identifying information was obtained.

A mailing list was purchased from a marketing organisation called *American Church Lists*. The mailing list had names and mailing addresses of religious congregations in St Louis City and St Louis County in Missouri. This list was cleaned and additional names

were added from other lists such as those found in the telephone book and on the Internet. The final mailing number was a total of 1334 congregations.

The original mailing was in June 2008. An initial postcard was sent to alert people that the survey would be coming in the mail. The following week, the survey was sent along with a cover letter addressed to the lead clergy person of the congregation, a stamped self-addressed return envelope, and a one dollar bill as a small token of thanks and to improve the response rate (Dillman, 2000). The following week, another postcard was sent to thank those who had already participated and to remind those who still wanted to participate that we would still like to hear from them. Study participants were also provided a website address so they could complete the survey online if they chose. A total of 111 surveys were returned as non-deliverable, and one was found to be a duplicate address. We were able to find new and/or corrected addresses for 96 of them to whom we re-mailed the survey. In response to this first mailing of the survey, 286 people returned completed surveys, and 36 people completed the survey online for a total of 322 completed surveys.

To increase the response rate, we did a second mailing to the same 1318 congregations we had identified earlier. This mailing consisted of a cover letter addressed to the lead clergy person of the congregation, the survey, a stamped self-addressed return envelope, and a one dollar bill as a small token of thanks. This time, 151 completed surveys were returned through the mail and 15 more were completed online. This yielded 473 hard copy surveys and 51 online surveys for a total of 524 surveys. However, we excluded 12 respondents from this study due to being from religions that did not provide ample cell sizes for meaningful analysis (three Reform and one Orthodox Jewish, one Hindu, one Scientology, three Unitarian/Universalist, and three ethical/spiritual societies), while some surveys were unusable due to excess missing data or a missing dependent variable. To avoid duplication we included a statement in the second mailing thanking people who had already responded and requesting that they not respond a second time. Our final usable response rate was 493 of 1318 (37.4%).

Measures

Dependent variable

Clergy likelihood of referral was ascertained through the question: "If I were to counsel an older adult with a mental illness, I would likely advise them to seek counseling from a medical doctor, a psychologist, a social worker, or other mental health professional." Possible response options ranged from 1 = strongly disagree to 5 = strongly agree. Due to a lack of distribution at the lower end, we recoded the items so that strongly disagree, disagree, and neutral responses = 0, and agree and strongly agree = 1.

Independent variables

Demographic data included gender, the respondent's self-identified race, level of education, age, number of years in the clergy, and size of his or her congregation. Since only 15 respondents reported their race as something other than Caucasian or African American, these cases were dropped from analyses. Education was dichotomised so that those with less than bachelor's degrees were coded as 0 and those with a bachelor's degree and greater were coded as 1. Age, years in the clergy, and size of congregations were continuous variables. Self-perception of how prepared respondents felt they were to

provide counselling for mental illness to older adults and their families was asked through the question: "I feel prepared to counsel older adults and their families about issues related to mental illness." Possible response options ranged from 1=strongly disagree to 5=strongly agree. The items were recoded so that strongly disagree, disagree, and neutral responses=0, and agree and strongly agree=1. The percent of time actually spent counselling older adults was asked: "What percent of your time is spent counseling adults age 55 and up?" This is a continuous variable. Religious affiliation was asked as an open ended question allowing respondents to self-identify as they chose. We then coded responses into three usable categories – Catholic/Roman Catholic ($n=75$), Mainline Protestant such as Lutheran, Methodist, and United Church of Christ ($n=161$), and Other Protestant such as Apostolic, Christian, and Southern Baptist ($n=257$). We used Other Protestant as the reference group in logistic regression analysis.

Clergy attitude towards older adults and mental illness was measured using a seven-item AOAMI measure. Items included such things as, "Anyone can develop a mental illness," "It is normal for older adults to be depressed," and "The majority of older people are at least a little senile." Possible response options ranged from 1=strongly disagree to 5=strongly agree. So that higher numbers would indicate more positive attitudes, some items were reverse scored. Due to a lack of distribution at the lower end, the items were recoded so that strongly disagree, disagree, and neutral responses=1, agree=2, and strongly agree=3 (range=7–21; $\alpha=.64$). Some of the questions were taken from the Black Rural and Urban Caregivers Mental Health and Functioning Study (Chadiha, Morrow-Howell, & Proctor, 2004), but prior psychometric data are not available as this is the first use of this complete scale. The quality of respondents' relationships with other professionals was ascertained by asking: "My professional relationships with other mental health providers (at mental health counseling centers, Alzheimer's Assoc., etc.) are very good." Possible response options ranged from 1=strongly disagree to 5=strongly agree. We recoded the items so that strongly disagree, disagree, and neutral responses=0, and agree and strongly agree=1. Knowledge of referral sources was one question: "If I were to counsel an older adult with a mental illness, I would know where to refer them for more help outside of our religious congregation." Possible response options ranged from 1=strongly disagree to 5=strongly agree. The items were recoded so that strongly disagree, disagree, and neutral responses=0, and agree and strongly agree=1.

For analysis in this paper, we included only those people who self-identified as either African American or Caucasian, and those who self-identified as belonging to a Christian denomination yielding a final sample of 493 respondents.

Data analysis

Central tendencies and distributions of all study variables were examined. Data were managed using SAS 9.2, and univariate analyses, bivariate analyses, and logistic regression were completed using STATA 11. Logistic regression analysis was employed to assess the relationship between the set of independent variables and the likelihood of referral to a formal source for additional help. After confirming the lack of relationship between observed variables and amount of missing data, the missing values for independent variables were imputed by using the method of imputation by chained equations (ice) (P. Royston, 2005a; P. Royston, 2005b). This imputation method uses a series of regressions in which a single variable is imputed based on a group of other variables (Van Buuren, Boshuizen, & Knook, 1999). Five data sets were created, and the averaged

unstandardised coefficients of these five data sets were produced. Because model fit for the imputed model cannot be formally tested, we examined the fit by using an unimputed model (complete case) and confirmed that the model fits the data well (data not shown).

Results

Sample characteristics

The ages of clergy members ranged from 26 to 83 with a mean of 55 ($SD = 10.6$), and the number of years they had served in the clergy ranged from 0 to 67 with a mean of 25 ($SD = 13.1$). A total of 424 clergy members (87.1%) had at least a bachelor's degree, and 131 (27.2%) reported their race as African American. A large majority of clergy members agreed or strongly agreed that if they were to counsel an older adult with a mental illness, they would likely advise him or her to seek counselling from a mental health professional ($n = 442$, 89.7%).

Bivariate differences based on advice to seek counselling

Clergy members' education, race, relationships with mental health professionals, knowledge of outside resources, attitude towards older adults and mental illness, and religious affiliations of mainline Protestant and other Protestant were associated with advising older adults to seek counselling (see Table 1). Specifically, those clergy members who had a bachelor's degree or higher ($\chi^2 = 10.66$, $p < 0.01$), who were Caucasian ($\chi^2 = 9.91$, $p < 0.01$), who had better relationships with mental health professionals ($\chi^2 = 4.15$, $p < 0.05$), who had greater knowledge of outside resources ($\chi^2 = 6.10$, $p < 0.05$), and who had a more positive attitude towards older adults and mental illness ($t = -4.50$, $p < 0.001$) were more likely to advise an older adult with a mental illness to seek additional professional help from a medical doctor, a psychologist, a social worker, or other mental health professional. In addition, those clergy whose affiliation was mainline Protestant were more likely ($\chi^2 = 5.83$, $p < 0.05$), and whose affiliation was other Protestant were less likely ($\chi^2 = 7.77$, $p < 0.01$) to advise an older adult to seek additional professional help.

Logistic regression results

Table 2 shows the results of logistic regression analysis. Those who had at least a bachelor's degree were 2.46 times more likely to advise older adults with a mental health issue to seek additional counselling as compared to those who did not have a bachelor's degree ($OR = 2.24$, $p < 0.05$). Being Mainline Protestant or Other Protestant, race (African American versus Caucasian), relationships with mental health professionals, and knowledge of outside resources were significant at the bivariate level of analysis but were no longer significant in the presence of other independent variables. Although clergy members' perceived preparedness for providing counselling was not significant at the bivariate level, it became significant after controlling other variables. For those who felt more prepared to counsel older adults and their families about mental illness issues, the odds of these clergy members advising older adults to seek counselling from a medical doctor, a psychologist, a social worker, or other mental health professional were 60% lower than those who did not feel as prepared ($OR = 0.40$, $p < 0.01$). The clergy members' attitudes towards older adults and mental illness stayed statistically significant, and those with a more positive attitude were 23% more likely to advise an older adult with a mental health issue to seek counselling ($OR = 1.23$, $p < 0.01$).

Table 1. Bivariate analyses ($N = 497$).

Variables	Refer for Additional Help $n = 442$		Not Refer for Additional Help $n = 51$		χ^2	t
	n (%)	Mean (SD)	n (%)	Mean (SD)		
Female	89 (20.4)		9 (18.4)		0.11	1.00
% of time spent counseling		9.7 (12.2)		11.3 (10.7)		
Bachelor's degree or more	387 (88.8)		37 (72.6)		10.77**	
Age		55.5 (10.6)		55.1 (11.2)		-0.29
Years in clergy		25.4 (13.3)		25.2 (11.1)		-0.11
Size of congregation		751.5 (1435.4)		587.7 (1010.6)		-0.78
Perceived preparedness to counsel	150 (34.4)		22 (43.1)		1.52	
African American	108 (25.1)		23 (46.0)		9.91**	
Good relations with MH providers	164 (38.1)		12 (23.5)		4.15*	
Knowledge of outside resources for help	316 (71.7)		28 (54.9)		6.10*	
Attitude towards older adults and MI		15.3 (2.7)		13.5 (3.2)		-4.50***
Catholic	69 (15.6)		6 (11.8)		0.52	
Mainline Protestant	152 (34.4)		9 (17.7)		5.83*	
Other Protestant	221 (50.0)		36 (70.6)		7.77**	

Notes: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.
 Highlighted figures indicate significant results.

Table 2. Logistic regression result for refer for additional help ($N = 493$).

Variables	OR	95% CI
Female	0.91	0.39–2.11
% of time spent counseling (square root)	1.00	0.97–1.02
Bachelor's degree or more	2.24	1.01–4.99*
Age	1.02	0.98–1.07
Years in clergy	0.99	0.95–1.03
Size of congregation (log)	1.00	1.00–1.00
Perceived preparedness to counsel	0.40	0.20–0.80**
African American	0.64	0.30–1.34
Good relations with MH providers	1.67	0.78–3.61
Knowledge of outside resources for help	1.78	0.92–3.44
Attitude towards older adults' MI	1.23	1.09–1.39**
Catholic vs. Other Protestant	0.91	0.25–3.35
Mainline Protestant vs. Other Protestant	1.28	0.53–3.11

Notes: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

Highlighted figures indicate significant results.

Discussion

This study used survey data to examine factors associated with the likelihood that clergy who counsel older adults would refer people for additional help from other formal sources (e.g., medical doctors, psychologists, social workers, or other mental health professionals). We found that clergy with more positive attitudes towards older adults' mental health issues would be more likely to refer people for additional help, and clergy with more education would be more likely to refer people for additional help. However, in multinomial regression models, clergy with better relationships with mental health professionals were not more likely to refer people for additional help, and clergy who had more knowledge of where to refer were not more likely to refer people for additional help.

Religious affiliation

While bivariate results indicated that Protestant clergy (either Mainline or Other Protestant in this analysis) were more likely to refer, those associations no longer held in the presence of other variables. One interpretation of the data is that having positive attitudes towards older adults' mental illness or having more education is more important to the decision-making process of whether clergy will refer than are denominational affiliations, knowledge of where to refer, or having better relationships with mental health professionals. Thus, we conclude that different clergy who are doing similar amounts of counselling are basing their decisions on whether to refer primarily on attitudes towards mental illness rather than on relationships with mental health professionals. Indeed, attitudes towards older adults and mental illness seemed to have trumped these other variables.

Education

In line with previous research (Gottlieb & Olsson, 1987), we found that respondents with more education were more likely to refer. However, we found that differences did not exist based on relationships with other professionals and on knowledge of where to refer,

though previous literature has found that insufficient knowledge (on the part of both clergy and mental health professionals) was an obstacle to collaboration (Oppenheimer et al., 2004). The fact that clergy who reported feeling more confident to counsel were less likely to refer might be a reflection of the positive effects of an overall increase in clergy's ability to make appropriate referrals due to the effects of pastoral training programs. On the other hand, it might reflect an overconfidence that means that some clergy might be providing services that might or might not be in line with those practices that mental health providers would consider being the most current evidence-based practices. It is unclear what, exactly, is going on in these meetings, and further evidence is needed before a definitive conclusion can be drawn.

Either way, our interpretation of the results leads us to suggest a point of intervention. In particular, we feel that public-private partnerships between mental health organisations and religious organisations that focus on training clergy how to identify warning signs of potentially greater problems has the ability to improve overall care for older people. Based on this study's finding that more positive attitudes increase the likelihood of referral, we believe that training for clergy should focus primarily on reducing stigma, improving attitudes, and increasing general knowledge of warning signs of the existence of mental illness in older adults. While previous works indicate that clergy with larger congregations are more likely to refer (Meylink & Gorsuch, 1988), this study did not find a difference based on congregation size, and it is possible that reaching out to clergy from differing sizes and types of congregations might be beneficial.

African American and Caucasian clergy

At the bivariate level, we found that Caucasian clergy were more likely to refer than their African American counterparts, but when controlling for other influences, no differences were found. A review of our results leads us to conclude that African American clergy might be less willing to refer overall, but that other factors such as education and attitudes towards older adults and mental illness might moderate this relationship.

Clergy provided counselling has been well established as one of the major services provided within African American religious communities (Chatters et al., 2010; Young et al., 2003). Accordingly, an examination of a *post-hoc* analysis in this study found that African American clergy spend more time counselling older adults than their Caucasian counterparts ($t = -4.04$, $p < 0.001$), though they do not report as good of relationships with mental health professionals ($\chi^2 = 6.24$, $p < 0.05$). Thus, we believe that African American clergy are doing more counselling while perceiving their relationships with the professional mental health community less desirable. However, since we lacked information on the specifics of the nature of the counselling that is provided, it is possible that African American clergy are counselling people for less serious mental health and emotional issues, and, therefore, feel less need to refer. Though this remains ambiguous, we, nonetheless, feel that outreach specifically to African American clergy for additional trainings could help to improve relationships with mental health professionals and help to reduce disparities in mental health treatment.

Limitations and future directions

Although this study was unique, it was still a regional cross sectional study, and conclusions regarding causation and generalisation were limited. For example, a more

rural sample, or even a sample drawn from regions other than an urban area in the Midwest, might have shown different attitudes towards older adults and mental illness, and different results might have been obtained. Also, we would have liked to have had more detailed information in some areas, such as differing levels of orthodoxy rather than just religious affiliation as an overarching variable, but the survey was kept to a brief length to help increase the likelihood that people would complete and return it (Dillman, 2000). For example, we would have liked to have known more about the nature of the counselling that clergy provide as well as the nature of the relationships between clergy and mental health professionals. In addition, future studies examining the possible effects that different denominations have on attitudes towards mental health and clergy's counselling practices would be helpful for a further understanding of a critical role of clergy in mental health service delivery. Perhaps, these are the types of questions that would be addressed better through a mixed methods analysis. Research alone is not enough, though. Mental health practitioners can assist in the development of trainings and outreach to help clergy provide better services that include referral when appropriate. Due to the important function that clergy serve in the *de facto* mental health system (Oppenheimer et al., 2004; Pickard, 2006; Wang et al., 2003), it is important to acknowledge that clergy are, indeed, providing very real mental health services and to assist them where possible.

Note

1. Clergy are religious leaders who have a mandate to conduct religious services, perform spiritual functions, and provide moral and spiritual guidance in the context of their particular faiths (US Department of Labor, 2010).

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