Clergy-Provided Mental Health Services: A Strategy for Addressing Disparities in Scale-up Efforts

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Abstract: *Most individuals with mental health needs do not receive professional care. One strategy to narrow this service provision gap is task-shifting, a process where certain responsibilities are shifted to less specialized workers. Approximately 25% of those who seek mental health care turn to clergy. This study investigated the suitability of using clergy to scale-up mental health service provision by assessing perceptions of satisfaction and helpfulness with clergy-delivered services. Using data from the National Comorbidity Survey Replication (2003), we found most respondents (n=204) who went to clergy reported satisfaction with their care (92%) and that the services were helpful (94%). Ordered logit regression revealed that racial/ethnic minorities and individuals for whom religion was more salient were disproportionately likely to find clergy-delivered mental health services satisfying and helpful, while older adults were more likely to report the services were helpful. The results suggest incorporating clergy in mental health scale-up plans via task-shifting may be a viable option, particularly for addressing the mental health needs of underserved racial and ethnic minorities, as well as older adults. Social workers—at least in theory—are well-positioned to collaborate with clergy in the process of implementing task-shifting.*

Keywords: *Health disparities; underserved populations; mental health services; scale-up; task-shifting, clergy*

For decades, researchers have noted that most people with mental health needs do not receive professional treatment (Substance Abuse and Mental Health Services Administration, 2017; Wang et al., 2005). Furthermore, quality mental health services have been inequitably distributed with, for example, racial and ethnic minorities having less access and receiving inadequate care (Puyat et al., 2016). Consequently, narrowing the treatment gap by scaling-up mental health services to achieve more equity is a pressing public health concern (Institute of Medicine, 2015).

Unfortunately, shortages in the mental health workforce exist, hindering scale-up efforts (Health Resources and Services Administration [HRSA], 2016). Researchers have documented the persistence of behavioral healthcare workforce shortages (Hoge et al., 2013). The HRSA (2016) projects the mental health workforce will need a quarter of a million additional providers to meet the demand for mental health care by 2025. The workforce shortages vary substantially by discipline and geographic region (HRSA, 2018). Furthermore, the number of Mental Health Profession Shortage Areas has increased over

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time (National Academies of Sciences, Engineering, and Medicine, 2017). Fortunately, strategies exist to narrow this workforce gap.

Several recommendations have been made to remediate workforce shortages, with some organizations and municipalities implementing various initiatives (Covino, 2019). For example, Olfson (2016) recommended: expanding loan repayment programs, increasing Medicaid reimbursement rates, augmenting training opportunities for social workers in evidence-based practices, and enhancing integrated care models (Olfson, 2016). Covino (2019) outlined efforts by seven states to address mental health workforce issues. Examples included encouraging graduate programs to train students in evidence-based practices, establishing Health Care Corps to bolster new professionals in the workforce, initiating cash incentive programs for workers, implementing performance-based bonuses, and starting a supervision training course (Covino, 2019). These efforts have made progress towards increasing and retaining the behavioral healthcare workforce; however, the gains pale in comparison to the projected workforce needs (Covino, 2019; Hoge et al., 2017). One recommendation that has yet to be fully implemented is to train family members, peers, and others in certain behavioral healthcare practices (Covino, 2019).

The World Health Organization (WHO, 2008) has promoted the use of task-shifting as one scale-up strategy to bolster the existing health service workforce. WHO (2008) defines task-shifting as "a process whereby specific tasks are moved, where appropriate, to health workers with shorter training and fewer qualifications" (p. 7). One example of task-shifting is training teachers and community health volunteers to provide Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to children in schools and community settings (Dorsey et al., 2020). Teachers and volunteers are trained in the TF-CBT model by experienced counselors and receive regular supervision and support in the implementation process (Dorsey et al., 2020). Task-shifting has been deployed for several behavioral health concerns (Deimling Johns et al., 2018; Javadi et al., 2017). Systematic reviews of behavioral health task-shifting have found the strategy to be both feasible and effective, resulting in improved behavioral health outcomes (Deimling Johns et al., 2018; Grant et al., 2018; Javadi et al., 2017). In addition to the teachers and volunteers cited above, other programs make use of lay community health workers (Hoeft et al., 2018).

One potential category of lay workers for task-shifting is clergy and other spiritual advisers. There are approximately 395,000 clergy in the United States (Association of Religion Data Archives, 2000; United States Census Bureau, 2012). These individuals interact with a substantial percentage of the American public. According to the Pew Research Center (2014), 36% of the general public attend religious services weekly, and 53% report that religion is a very important component of their lives. Furthermore, religion tends to be more salient in communities that are underserved in the area of mental health services including Blacks, Hispanics, women, older adults, and people with low incomes (Newport, 2012).

People often turn to clergy for assistance when they experience problems. Indeed, clergy have been functioning as de facto frontline mental health workers for decades (Weaver et al., 2003; Wong et al., 2018). Clergy provide various types of emotional support to their congregants, with individuals frequently seeking clergy out for mental health

concerns (Hedman, 2014; VanderWaal et al., 2012). Clergy report dedicating, on average, 15% of their time to pastoral counseling activities, which by one estimate would yield approximately 138 million hours of mental health support services per year (Weaver et al., 2003). Clergy help people cope with a wide range of stressors, life transitions, and mental illnesses (Payne, 2009, 2014; VanderWaal et al., 2012). Furthermore, approximately one-third of church attendees belong to a congregation that provides formal support for individuals with a mental illness (Wong et al., 2018). Wang et al. (2003) found that 25% of adults who sought mental health services turned to clergy for care. Among adults aged 55 and over, approximately 32% of individuals with a serious physical or emotional problem sought help from clergy (Nguyen et al., 2020). Most of those who saw clergy decided to work with them exclusively and did not receive adjunctive services from physicians or mental health professionals (Wang et al., 2003).

Various explanations have been offered to explain why some people prefer to receive services from clergy (Payne, 2009, 2014). Clergy often have long-term relationships with their congregants which is conducive to building trust and observing shifts in mood/behavior (Ellison et al., 2006). Many individuals believe religion is an important dimension of wellness (Pew Research Center, 2014), and may prefer providers who can incorporate spiritual resources into service provision in a culturally competent manner (Chalfant et al., 1990). Less stigma may be associated with seeking help from clergy, along with an absence of fees and quicker access to services (Payne, 2009, 2014; VanderWaal et al., 2012). Some have posited that certain racial and ethnic groups may be inclined to seek out assistance from clergy rather than other providers due to distrust based on historic abuses by the health care system (Brown & McCreary, 2014). Individual characteristics such as race/ethnicity, age, education, religious salience, and the nature of the presenting problem have been associated with seeking mental health care from clergy (Brown & McCreary, 2014; Chatters et al., 2011; Dalencour et al., 2017; Nguyen et al., 2020). Another possibility is that the services provided by clergy are effective, mitigating the need to obtain services from traditional mental health providers. Indeed, some evidence suggests the services delivered by religious leaders, delivered in churches, or therapies that accommodate client religious/spiritual practices may be effective (Gonçalves et al., 2015; Hook et al., 2010; Worthington et al., 2011).

Questions remain, however, about the perceived satisfaction and helpfulness of clergy-delivered mental health services. Our use of the phrase "mental health services" views mental health care as a continuum of services provided by socially sanctioned helpers (e.g., social workers, psychologists, clergy; Jameson & Naugle, 2013; Milstein et al., 2008). These helpers provide a range of services—from prevention through intervention—aimed at improving individuals' emotional, psychological, and social lives (Milstein et al., 2008). Relatively little research has examined the perceived satisfaction and helpfulness of clergy-provided mental health services using cross-group comparisons (Ellison et al., 2006; Neighbors et al., 1998; Veroff et al., 1981). To address this gap, the present study examined two key outcomes across several groups, namely clients' perceived: 1) satisfaction with, and 2) helpfulness of clergy-delivered mental health services.

Satisfaction with services is an important dimension to consider when assessing the quality of mental health care (Fortin et al., 2018). In the broader health services literature,

patient satisfaction is associated with positive clinical outcomes (Doyle et al., 2013). The mental health services literature has not identified consistent socio-demographic predictors of satisfaction, and limited research exists on satisfaction with clergy-delivered mental health care (Fortin et al., 2018). The extant research suggests that members of racial and ethnic minority communities generally find clergy-delivered mental health services satisfying (John & Williams, 2013; Neighbors et al., 1998). The methods employed in these studies, however, preclude making national cross-group comparisons.

Systematic reviews on faith and traditional healing in mental health have identified helpfulness as a good proxy for service effectiveness (Nortje et al., 2016; van der Watt et al., 2018). Research suggests that clergy-delivered services are generally viewed as helpful (van der Watt et al., 2018; Veroff et al., 1981). However, as is the case with satisfaction, the methods used in the existing research do not allow for national cross-group comparisons.

To address these limitations, the present study used a nationally representative dataset to investigate clients' perceived satisfaction with, and helpfulness of, clergy-delivered mental health services. To help determine the suitability of using clergy as scale-up mental health service providers, this study was guided by four questions. Among clients who receive mental health services from clergy 1) how satisfied are clients with the services they received? and 2) how helpful are the services? What predictors are associated with clients' perceived 3) satisfaction, and 4) helpfulness of services. Based upon the extant literature, we tentatively hypothesize that most clients will report being satisfied with services and will report the services as helpful. We also expect that several variables will predict both satisfaction and helpfulness including potentially race/ethnicity, age, and religious salience (Ellison et al., 2006; John & Williams, 2013; Neighbors et al., 1998; Wang et al., 2003).

Methods

Sample

To answer these questions, the authors used data from the National Comorbidity Survey Replication (NCS-R; Alegria et al., 2016). The NCS-R is a nationally representative survey conducted in 2003 with approximately 10,000 respondents (Kessler & Merikangas, 2004). Although the NCS-R was administered in 2003, it continues to be widely used due to the breadth of mental health variables included in this dataset (Kolla et al., 2020; Stickley et al., 2020). Pertinent to our study, the NCS-R included information regarding mental health treatment receipt, satisfaction with treatment, and helpfulness of service provision (Kessler & Merikangas, 2004). Following the procedures used by other researchers (Kovess-Masfety et al., 2010), we used a subset of NCS-R for our study.

The NCS-R screened for lifetime mental health service use using various questions (e.g., "Did you ever in your lifetime go to see any of the professionals on this list for problems with your emotions, nerves, or your use of alcohol or drugs?"). Respondents who had received services in their lifetime were given a list of mental health providers, one of which was, "a religious or spiritual advisor like a minister, priest, or rabbi." Respondents

were asked when they last received services from the providers they selected. Additional questions for each provider were asked of those who reported receiving services within the past 12 months.

Some 249 individuals reported receiving mental health services from clergy in the prior 12 months. Among these, 45 (18.1%) had missing values in the predictor, dependent variables, or weighting variable. Sensitivity analyses showed that observations with missing values did not differ statistically from the remaining sample; and models with imputed data had the same results as models using list-wise deletion. Therefore, individuals who had valid responses to all the variables in our models were included in our analyses. After applying the survey weights (Kessler et al., 2004), we ended up with a study sample of 204.

Variables

Dependent Variables

The two dependent variables in this study were client perceptions of satisfaction and helpfulness of clergy-provided mental health services (Harris et al., 2020; Lippens & Mackenzie, 2011). Client satisfaction was assessed with the following item: "In general, how satisfied are you with the treatments and services you received from the spiritual advisor or religious leader in the past 12 months?" Participants indicated their response on a five-point ordinal Likert scale ("very satisfied," "satisfied," "neither satisfied or dissatisfied," "dissatisfied," or "very dissatisfied"). Consistent with other studies (O'Connell et al., 1999), preliminary analysis revealed that few respondents reported any degree of dissatisfaction. Consequently, the variable was recoded into three categories as follows: "very dissatisfied/dissatisfied/neither satisfied or dissatisfied," "satisfied," and "very satisfied" (Alang & McAlpine, 2020, 2019; Lippens & Mackenzie, 2011).

Helpfulness was measured with the following item: "Did the spiritual advisor help you a lot, some, a little, or not at all?" Few respondents reported receiving little or no help. As was the case with the satisfaction measure, we followed common practice and collapsed the responses to create a new variable consisting of three categories: "not at all/ a little", "some", and "a lot" (Alang & McAlpine, 2019, 2020; Lippens & Mackenzie, 2011).

Predictor Variables

The selection of predictor variables was based upon previous studies investigating the use of clergy in mental health service provision (Kovess-Masfety et al., 2010; Wang et al., 2003). Drawing from this work, the demographic predictors included in the present study consisted of sex, age, race/ethnicity (non-Hispanic White, Black, Hispanic), education level (less than high school, high school, some college, college graduate), employment status (employed, unemployed/not in labor force), marital status (married/cohabiting, divorced/separated/widowed, never married), and geographic region (Northeast, Midwest, South, West).

Religious salience indicators included: frequency of attending religious services (never, less than once a month, one to three times per month, about once a week, more than

once a week), and the importance of one's religious beliefs (not at all important, not very important, somewhat important, very important). We calculated a sum score of religious salience by adding the standardized attendance frequency and the standardized rating of religious importance.

Analysis

All univariate tests and ordered logit models were conducted using Stata V14. Univariate analysis was used to answer the first and second research questions, specifically, by examining the responses to the questions about clients' perceptions of satisfaction with, and helpfulness of, clergy provided mental health services. Ordinal logit regression models were used to answer the third and fourth research questions regarding predictors of satisfaction and helpfulness. Multinomial and generalized ordered logit models were used as robustness checks. These robustness-check models confirmed the findings for both ordinal logit models. We also ran the model predicted probabilities based on average marginal effects. Average marginal effects compute the marginal effect of the predicted coefficients for each observation at its observed values and then computes the average of these effects (Long & Freese, 2014).

The authors conducted diagnostic tests to ensure the assumptions of ordered logit regression were not violated. They assessed multicollinearity using the Variance Inflation Factor (VIF) and Pairwise Correlations. The mean VIF was 1.19 and none of the pairwise correlations were above the .6 cutoff. These values suggest that multicollinearity was not problematic (Kutner et al., 2004). We assessed the parallel lines assumption or proportional odds assumption using the Brant test (Long & Freese, 2014). The results were not significant, indicating we could assume the relationship between all pairs of groups was the same.

Results

Sample Description

Table 1 presents the demographic characteristics of the sample (n=204). Respondents were mostly female (n=144, 70.6%), White (n=151, 74.0%), employed (n=139, 68.1%), and married/cohabiting (n=100, 49.0%). About one-third of respondents resided in the Midwest (n=64, 31.4%), and in the South (n=66, 32.4%), while the rest lived in the Northeast (n=31, 15.2%) and the West (n=43, 21.1%). Ages ranged from 18 to 84 years, with a mean age of 38.1 years (SD=13.44 years). A majority attended at least some college (n=128, 62.7%), attended church services at least weekly (n=124, 60.7%), and viewed religious beliefs as very important (n=171, 83.8%).

Table 1. *Descriptive Characteristics of Sample (n=204)*

Characteristic	*n* (%)
Sex	
Male	60 (29.4%)
Female	144 (70.6%)
Ethnicity	
White	151 (74.0%)
Black	31 (15.2%)
Hispanic	22 (10.8%)
Education level	
Less than high school	25 (12.3%)
High school graduate	51 (25.0%)
Some college	71 (34.8%)
College graduate and above	57 (27.9%)
Employment status	
Employed	139 (68.1%)
Unemployed or not in labor force	65 (31.9%)
Marital status	
Married/cohabiting	100 (49.0%)
Divorced/separated/widow	49 (24.0%)
Never married	55 (27.0%)
US geographic region	
Northeast	31 (15.2%)
Midwest	64 (31.4%)
South	66 (32.4%)
West	43 (21.1%)
Religious services attendance	
Never	14 (6.9%)
Less than once per month	31 (15.2%)
1-3 times per month	35 (17.2%)
About once per week	67 (32.8%)
More than once per week	57 (27.9%)
Importance of religious beliefs	
Not at all important	1 (0.47%)
Not very important	9 (4.41%)
Somewhat important	23 (11.27%)
Very important	171 (83.82%)
Satisfaction with clergy-based MH care	
Very dissatisfied, dissatisfied, neutral	16 (7.8%)
Satisfied	50 (24.5%)
Very satisfied	138 (67.7%)
Perceived helpfulness of clergy-based MH care	
Not at all, a little	13 (6.3%)
Some	48 (23.5%)
A lot	143 (70.1%)
	Mean (*SD*)
Age (range 18 ~ 84)	38.1 (13.44)
Religious salience score (range -5.24 ~ 1.53)	-0.003 (1.63)

Satisfaction and Helpfulness of Clergy-Provided Mental Health Services

Univariate analysis indicated our first and second hypotheses were supported. Most respondents reported being either very satisfied (n=138, 67.7%) or satisfied (n=50, 24.5%). In other words, 92.2% (n=188) of respondents indicated some degree of satisfaction with the mental health services they received from clergy. Similarly, most respondents reported the degree of helpfulness of clergy-delivered mental health services as "a lot" (n=143, 70.1%) or "some" (n=48, 23.5%). Put differently, 93.6% (n=191) of respondents indicated the mental health services they received from clergy were helpful.

Table 2. *Differences in Predicted Probabilities and Odds Ratios of Client Satisfaction With Clergy-Delivered Mental Health Services for Selected Groups*[a] *(n=204)*

	Satisfaction With Clergy-Delivered Mental Health Services			Odds Ratio [c]
Characteristics	Dissatisfied	Satisfied	Very satisfied	exp(B)
All [b]	0.089	0.207	0.704	
Sex (Female vs. Male)	0.013	0.017	-0.029	0.837
Age (Every one standard deviation increase)	-0.028[t]	-0.041	0.069[t]	1.556
Ethnicity				
Black vs. White	-0.082**	-0.146*	0.229**	4.864*
Hispanic vs. White	-0.069[t]	-0.112*	0.180*	3.132[t]
Hispanic vs. Black	0.014	0.034	-0.048	
Education level				
High school vs. Less than high school	0.017	0.018	-0.035	0.832
Some college vs. Less than high school	-0.020	-0.026	0.046	1.289
College vs. Less than high school	-0.063	-0.105	0.167	2.858
Some college vs. High school	-0.036	-0.045	0.081	
College vs. High school	-0.079	-0.123*	0.202[t]	
College vs Some college	-0.043	-0.078	0.121	
Employment status				
Employed vs. Unemployed/Not in labor force	-0.034	-0.042	0.075	1.556
Marital status				
Divorced/Widowed vs. Married	-0.021	-0.026	0.048	1.332
Never Married vs. Married	-0.025	-0.033	0.058	1.423
Never Married vs. Divorced/Widowed	-0.004	-0.006	0.010	
U.S. geographic region				
Midwest vs. Northeast	0.058	0.078	-0.136	0.426
South vs. Northeast	0.068[t]	0.087	-0.155	0.383
West vs. Northeast	-0.014	-0.027	0.041	1.374
South vs. Midwest	0.010	0.010	-0.019	
West vs. Midwest	-0.072	-0.104[t]	0.177[t]	
West vs. South	-0.082*	-0.114*	0.196*	
Religious salience score (Every one standard deviation increase)	-0.035*	-0.055**	0.090**	1.816**

[a] *Predictions based on estimated coefficients of the ordered logit model, calculated as average marginal effects.*
[b] *Average predicted probabilities of all sample participants.*
[c] *Indicator variables odds ratio is exp (B), continuous variables odds ratio based on one std1 deviation increase.*
*[t]p<.10, *p<.05, **p<.01, ***p<.001*

Satisfaction Ordinal Logit

We modeled the first ordered logit regression with perceived satisfaction as the dependent variable (χ^2 =38.47, *df* =14, *p*=.0004). The pseudo R^2 suggested that the predictors in the model explained 11.3% of the variance. The odds ratios and average marginal effects of the weighted ordered logit model are shown in Table 2.

In keeping with our expectations, race/ethnicity and religious salience were significant predictors of satisfaction. The odds ratios of Black versus White and Hispanic versus White are estimated as 4.864 (p<0.05) and 3.132 (p<0.10). This means the odds of rating "very satisfied" versus the combined outcomes of "satisfied" and "very dissatisfied/ dissatisfied/ neutral" are 4.864 and 3.132 times higher for Black and Hispanic participants relative to their White counterparts. The difference between Hispanic and White participants was only significant at a non-traditional, trend level (i.e., <0.10 instead of < 0.05).

As for religious salience, the odds ratio is estimated as 1.816 (p<0.01). This means the odds of rating "very satisfied" versus the combined outcomes of "satisfied" and "very dissatisfied/ dissatisfied/ neutral" are 1.816 times higher for participants as their religious salience score (a sum score of standardized religious attendance and religious importance) increases by one-standard deviation (1.63 units). This outcome suggests our third hypothesis was supported.

Helpfulness Ordinal Logit

We modeled the second ordered logit regression with perceived helpfulness as the dependent variable (χ^2 =33.68, *df* =14, *p*=.0023). The pseudo R^2 suggested that the predictors in the model explained 10.5% of the variance. Table 3 presents odds ratios and average marginal effects of the weighted ordered logit model.

Consistent with our expectations, race/ethnicity, age, and religious salience were significant predictors of helpfulness. The odds ratios for Black versus White and Hispanic versus White are respectively estimated as 3.390 (p<0.10) and 5.117 (p<0.05). This means the odds of rating "a lot" versus the combined outcomes of "some" and "not at all/ little" are 3.39 times higher for Black participants and 5.12 times higher for Hispanic participants relative to their White counterparts. The difference between Black and White participants was only significant at a non-traditional, trend level (i.e., <0.10 instead of < 0.05). The odds ratio of age is estimated as 1.623 (p<0.05), meaning the odds of rating "a lot" versus the combined outcomes of "some" and "not at all/ little" are 1.623 times higher for participants with each one-standard deviation (13.4 years) increase in age.

Religious salience was also a significant predictor of helpfulness. The odds ratio for this predictor is estimated as 1.582 (p<0.01). This means the odds of rating "a lot" versus the combined outcomes of "some" and "not at all/ little" are 1.582 times higher for participants as their religious salience score (a sum score of standardized religious attendance and religious importance) increased by one-standard deviation (1.63 units). Accordingly, our fourth hypothesis was supported.

Table 3. *Differences in Predicted Probabilities and Odds Ratios of Perceived Helpfulness of Clergy-Delivered Mental Health Services for Selected Groups*[a] (*n*=204)

	Helpfulness of Clergy-Delivered Mental Health Services			Odds Ratio[c]
Characteristics	Not at all/ Little	Some	A lot	exp(B)
All[b]	0.077	0.221	0.702	
Sex (Female vs. Male)	0.031	0.056	-0.087	0.596
Age (Every one standard deviation increase)	-0.026*	-0.050*	0.076**	1.623*
Ethnicity				
Black vs. White	-0.064*	-0.130*	0.195*	3.390[t]
Hispanic vs. White	-0.075*	-0.164**	0.239**	5.117*
Hispanic vs. Black	-0.011	-0.034	0.044	
Education level				
High school vs. Less than high school	-0.005	-0.007	0.012	1.060
Some college vs. Less than high school	-0.039	-0.062	0.101	1.701
College vs. Less than high school	-0.066	-0.126[t]	0.193[t]	3.055[t]
Some college vs. High school	-0.034	-0.055	0.089	
College vs. High school	-0.061	-0.119	0.181	
College vs Some college	-0.028	-0.064	0.092	
Employment status				
Employed vs. Unemployed/Not in labor force	-0.032	-0.052	0.084	1.606
Marital status				
Divorced/Widowed vs. Married	-0.026	-0.042	0.068	1.483
Never Married vs. Married	-0.033	-0.054	0.087	1.671
Never Married vs. Divorced/Widowed	-0.007	-0.012	0.019	
U.S. geographic region				
Midwest vs. Northeast	0.016	0.030	-0.045	0.756
South vs. Northeast	0.023	0.042	-0.065	0.674
West vs. Northeast	0.025	0.045	-0.070	0.655
South vs. Midwest	0.007	0.012	-0.020	
West vs. Midwest	0.009	0.015	-0.025	
West vs. South	0.002	0.003	-0.005	
Religious salience score (Every one standard deviation increase)	-0.025*	-0.048**	0.073**	1.582**

[a] *Predictions based on estimated coefficients of the ordered logit model, calculated as average marginal effects.*
[b] *Average predicted probabilities of all sample participants.*
[c] *Indicator variables odds ratio is exp (B), continuous variables odds ratio based on one std. deviation increase.*
[t] *p<.10, *p<.05, **p<.01, ***p<.001*

Discussion

The treatment gap for mental illnesses is among the highest in the larger health sector (Trautmann et al., 2016). This has led to calls to scale-up care (Chisholm et al., 2016). In light of the shortages that exist among the professional mental health workforce (Health Resources and Services Administration, 2016), the WHO (2008) and other organizations have suggested using task-shifting as one option to address this emerging crisis. This study examined the suitability of using clergy to scale-up mental health service provision by measuring clients' perceptions of satisfaction with, and the helpfulness of, clergy-delivered

mental health services. Unless clients are satisfied with the services they receive and view them as helpful, it makes little sense to consider clergy as candidates for task-shifting.

Consistent with our hypotheses, individuals who received mental health services from clergy were likely to find it satisfying and helpful. Approximately 92% of respondents reported that they were either very satisfied (68%) or satisfied (24%) with the services. Similarly, 94% of respondents reported the services helped them some (24%) or a lot (70%). Racial and ethnic minorities, older adults, and individuals for whom religion was more salient were particularly likely to report the mental health services they received from clergy were helpful. These findings are consistent with prior research (Payne, 2014; Wang et al., 2003, 2006; Weaver et al., 2003).

This study also investigated the determinants of perceived satisfaction and helpfulness of clergy-delivered mental health services by conducting a cross-group comparison. Prior research has found that racial and ethnic minorities generally find clergy-delivered mental health services to be satisfying (John & Williams, 2013; Neighbors et al., 1998). For the broader population, overall levels of perceived helpfulness and satisfaction with other mental health professionals is similar to those for clergy (e.g., Harris et al., 2020; Lippens & Mackenzie, 2011). In some cases, levels of perceived helpfulness of clergy are higher than some professional categories (Kuramoto-Crawford et al., 2015). This work confirms this finding and extends it by illustrating that some racial and ethnic minorities—namely individuals in the Black and Hispanic communities—are more likely to find the services satisfying or helpful than their White counterparts. This finding has important implications for addressing health disparities in mental health service provision.

Implications for Mental Health Service Provision

In the present study, the groups who were more likely to find clergy-delivered mental health services satisfactory and helpful are typically underserved by mental health professionals (Puyat et al., 2016; Wang et al., 2006). Blacks, Hispanics, and other racial and ethnic minorities are particularly disadvantaged when it comes to obtaining mental health services, as they frequently have less access to mental health services and are less likely to receive quality care (Lukachko et al., 2015; McGuire & Miranda, 2008). Similarly, older adults have low use of mental health care, partially due to the discomfort associated with seeking formal mental health services (Byers et al., 2012). Older individuals tend to have shrinking networks of social support, resulting in increased reliance on informal systems of care that exist outside of the formal mental health system (Wrzus et al., 2013).

Vulnerable populations may be especially likely to benefit from clergy-provided services since the services often circumvent the barriers that inhibit the receipt of traditional mental health care (VanderWaal et al., 2012). Approaching a clergy person for support does not typically carry the stigma that deters many from seeking mental health treatment from traditional venues (Payne, 2009, 2014). For example, older adults may already be embedded in a congregational context in which seeing clergy is normative. In addition, the costs for usual services can impede many from receiving care (Payne, 2014). Clergy generally do not charge fees for their services (Payne, 2009). Therefore, receiving help

from clergy is less stigmatizing, more affordable, and individuals often have a shared cultural connection with the provider (VanderWaal et al., 2012).

There have been calls for increased collaboration between clergy and mental health providers to overcome years of distrust (Aten & Worthington, 2009; Breuninger et al., 2014; Sullivan et al., 2014). Commentators have noted that collaboration can be mutually beneficial (Oppenheimer et al., 2004). Some clergy feel they are well-positioned to treat mental illness (Hedman, 2014; Payne, 2014), seeing mental health education as an expression of their vocation (Hedman, 2014), while others who feel less qualified may still be willing to counsel individuals with mental illness (Farrell & Goebert, 2008). Attitudes towards referring clients vary, with some clergy willing to refer clients for professional care while others are hesitant (Ali & Milstein, 2012; Pillion et al., 2012). While progress has been made (Breuninger et al., 2014; Sullivan et al., 2014), historically, psychotherapists have been far less willing to refer clients to clergy for spiritual help (Oppenheimer et al., 2004).

Notwithstanding the important role clergy could play in mental health service scale-up efforts, additional facets of their service should also be considered. For example, serving as a clergy person is taxing and may lead to burnout (Jackson-Jordan, 2013). Adding mental health service tasks without commensurate support could lead to further depletion of clergy. Another pertinent issue is training. Knowledge about mental illness among clergy varies widely (Vermaas et al., 2017). Many clergy have expressed interest in mental health-related training, and initial studies have found that even brief training can increase clergies' sense of competence in dealing with mental health issues (Chevalier et al., 2015; Payne, 2014). Questions remain, however, about how much training should be required (Payne, 2014).

As is the case with all scale-up efforts, infrastructural challenges exist concerning incorporating clergy. Historical barriers exist between the mental health establishment and many religious institutions, which require addressing (Queener & Martin, 2001; Weaver et al., 2003). Questions also exist about what sort of tasks would best fit clergy, what supervision structures/capacity are necessary to support the execution of those tasks, and how social workers might participate in this process.

Implications for Social Work

In theory, social workers are well-positioned to collaborate with clergy in the process of implementing task-shifting (Williams et al., 2014). Many social workers are already embedded in congregations (Garland & Yancey, 2014). In some cases, congregations employ social workers along with clergy (Lehmacher, 1997). These congregationally-based social workers are perhaps ideally situated to facilitate linkages between the profession and clergy.

Also significant, are the growing number of social work programs offering MSW students the opportunity to obtain a joint Master of Divinity degree (Muehlhausen, 2010). Such dual degree graduates may also be uniquely equipped to broker task-shifting arrangements. More specifically, these and other social workers might provide clergy education, training, and supervision, while engaging with faith communities to raise

awareness and reduce stigma regarding mental health challenges (VanderWaal et al., 2012; Williams et al., 2014).

It is important to note, however, that task-shifting is not a panacea and unresolved issues remain regarding social work participation in this process. Some clients may wish to see clergy due to the distinct set of spiritually-informed services they offer. Furthermore, individuals for whom religious salience is a key dimension of their identities may be hesitant to work with traditional mental health professionals due to concerns about the providers' lack of religious competency (Oxhandler et al., 2015. As alluded to above, anti-religious bias (Hodge, 2007; Thyer & Myers, 2009), as well as racial bias (Corley & Young, 2018), has been documented in the social work profession. This may help explain why members of the Black community are disproportionately likely to avoid seeking professional help due to concerns about lack of respect for their religious beliefs (Boorstin & Schlachter, 2000).

Another challenge pertains to what might be called turf sharing. For task-shifting to function effectively, mutual respect needs to exist between clergy members and social workers. Accordingly, it is critical that social workers engage with clergy as equal partners in the task of helping people struggling with mental health challenges. Toward this end, adopting an approach grounded in cultural humility can help social workers to build bridges with clergy (Gottlieb, 2020).

Despite these potential challenges, the larger umbrella of the U.S. mental health care system might be strengthened if social workers and clergy develop professional relationships that are meaningful, bidirectional, and intentional. These collaborative relationships might take many forms. For example, they could include training clergy in foundational mental health approaches such as motivational interviewing; clergy-delivered training to mental health providers on culturally-responsive practices with people of faith; partnered care delivery with clergy and other providers addressing different components of care; embedding clinical practitioners in churches and clergy in clinics; or, co-facilitation of treatment groups and community workshops. The permutations of possible collaborations are vast. Perhaps most importantly, collaboration between social workers and clergy would potentially aid in the provision of more affordable, culturally-sensitive mental health care for marginalized populations.

Limitations

This study's contributions should be interpreted in the context of the following limitations. First, the study dataset provides a nationally representative snapshot of mental health service use; but the NCS-R was not specifically designed to assess clergy-delivered services. As such, the generalizability of the findings may be uncertain. Ideally, our findings might be validated using samples comprised solely of recipients of clergy-delivered mental health services. Nonetheless, using a subset of nationally representative surveys to explore questions on religion and mental health service use is a common practice (Kovess-Masfety et al., 2010; Lukachko et al., 2015; Nguyen et al., 2020). In theory, such a subset should be nationally representative of the underlying group, in this case, people who obtained mental health services from clergy during the prior year (Babbie, 2016).

The results of the current study need to be interpreted with caution because of the small sample size. For instance, it is possible that individuals who are older, less-educated, racial or ethnic minorities, and male were underrepresented in our study due to error associated with small sizes. Although the NCS-R is still in wide use, it is important to note that roughly 20 years have transpired since the data were collected. It is possible that perceptions concerning clergy-provided mental health service have changed over the intervening years (Pew Research Center, 2019).

Another limitation involves the nature of self-selection. To be included in our study, individuals needed to endorse receiving mental health services from clergy in the past 12 months. Endorsing such an item implies respondents recognized their need for services and viewed clergy as addressing that need. It is possible other individuals had the same mental health needs and received similar services from clergy, but did not consider it a mental health service. The NCS-R survey item that asked about the receipt of mental health services featured a list of traditional mental health service providers (e.g., social workers, psychiatrists, psychologists) along with clergy. This list hopefully primed respondents to consider potential mental health services they may have received from clergy. However, it is possible that they viewed their interactions with clergy differently from the other listed professionals due to the spiritual vocation of clergy. Alternatively, some individuals may have experienced clergy-delivered support as unhelpful, but did not report it.

Another potential limitation is the use of single items to determine perceived satisfaction and helpfulness. Ideally, multi-item measures would have been used to measure these constructs. However, single item measures have been used in mental health services research (Lippens & Mackenzie, 2011), and researchers are finding increasing utility in single item measures (Ahmad et al., 2014). This suggests some degree of confidence in the findings is warranted.

Conclusion

This study examined the suitability of including clergy as providers in mental health scale-up plans based on the perceived satisfaction and helpfulness of their services. Using a nationally representative dataset allowed for cross-group comparisons which adds to the current literature on clergy-delivered mental health care. Nearly all the clients found clergy-delivered mental health care satisfying (92%) and helpful (94%), particularly racial and ethnic minorities, older adults, and individuals for whom religious salience is an important dimension of their identities. Given the percentage of people who turn to clergy for mental health services, clergy could be a substantial resource for scaling-up mental health care (Young et al., 2003) especially for Blacks, Hispanics, and older adults. Given that members of these communities have traditionally been underserved in the mainstream mental health system, the results can potentially play an important role in reducing mental health disparities.

Several questions remain about the role of clergy in mental health service scale-up efforts that future research might examine. The extant research outlines clergy attitudes towards mental illness, their willingness to provide care, and referral practices. Conversely, much less is known about how large, public mental health systems can meaningfully

incorporate clergy in scale-up efforts. Historically, clergy and mental health professionals have operated largely in parallel and disconnected tracks. Additional research on the best ways of leveraging these parallel systems of care is needed. Areas of exploration include: how clergy can be supported in their gate-keeping functions, how to support clergy involved in direct counseling efforts (e.g., training and supervision structures), the degree to which clergy training should include mental health topics, congregant attitudes towards seeking help from clergy with subjects taboo to their religion, how the mental health system can better refer clients to their religious leaders and communities, best practices for engaging and retaining cross-discipline partnerships, and how to ensure safety and quality care. Additional research is needed on the nature of clergy-delivered mental health services. For example, relatively little is known about the specific practices clergy employ (content of the care), the "dosage" of care they provide, the effectiveness of services, and the mediators of change. The contributions of the present study provide an important foundation to examine these and other questions about the role of clergy in potential task-shifting collaborations with social workers and other mental health providers.

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