THE Lutheran Foundation

Mental and Behavioral Health Needs Assessment

The Lutheran Foundation

February 2014

Table of Contents

Executive Summary

The intent of this section is to provide the pithiest and most salient view of the key findings that may impact The Lutheran Foundation's strategic direction over the next few years:

- ➢ Traditional protective factors such as family and religion are fraying, especially in the non-urban counties served by The Lutheran Foundation:
  - Churches and religion play a surprisingly small role in the lives of most people in The Lutheran Foundation's service area. This phenomenon remains true even outside of Allen County. More than half of the residents in most counties in the service area are not affiliated with a church or an organized religion. In effect, religion as a protective factor is very weak even in non-urban counties, which is counterintuitive but important to recognize.
  - On a statistically significant level, residents of non-urban counties perceive protective factors, with the exception of family support, as weaker, if not altogether lacking, in their communities than do residents of Allen County. Protective factors simply do not seem to be as visible or present, which is somewhat counterintuitive and contrary to the stereotypes of rural society.
  - Populations in non-urban counties are simultaneously contracting, aging, and diversifying racially and ethnically. Each of these populations requires distinct protective factors that differ from those normally associated with non-urban areas.
  - Adults who live with no other adults, including but not limited to seniors, are statistically less likely than the general population to participate in wider social interactions.
- ➢ For those in non-urban counties, schools are perceived at a statistically significant level as the original source of referral, the "front door" to accessing mental or emotional health services for their children. Schools, however, report being ill-equipped to deal with mental and behavioral health issues and capable of, if anything, little more than making referrals.
- ➢ Those who want mental or emotional health services for themselves, other adults in their household, or their children do not know, at a statistically significant level, how to begin accessing those services.
- ➢ Higher income people access mental and emotional health services more easily and successfully than lower income people, again at a statistically significant level.
- ➢ Of the 260 (65%) respondents to the household survey who indicated that they had experienced one or more of the feelings associated with mental or behavioral problems— fidgetiness, anxiety, depression, worthlessness, or hopelessness—within the 30 days prior to their participation in the survey, only 16 had seen a physician or another professional about their symptoms.
- ➢ At a statistically significant level, men perceived less risk than did women in consuming 3 or more drinks each day and in using tobacco, marijuana, and other illegal drugs. They also perceived less risk in mixing alcohol with prescription or over-the-counter medications.
- ➢ Symptoms of depression more frequently occurred at a statistically significant level among people who were living with no other adults than those who were living with other adults.
- ➢ Blacks were statistically more likely than other populations to have a sense of worthlessness, at least in the 30 days prior to taking the survey.

➤ Anxiety was the symptom most closely associated with younger people. Those who reported nervousness in the 30 days prior to responding to the survey were statistically significantly younger than those who did not experience the symptom.

➤ School personnel responding to the survey universally reported that learning challenges were a potent threat to students' mental and emotional well-being. There were no county-level differences in this perspective. However, Lutheran schools tended to report more "soft" issues—academic achievement, learning challenges, developmental issues, interpersonal relationship issues, and self-esteem problems—than non-Lutheran schools, where the issues tended to be "harder"—anger, externalizing behavior, or lack of motivation—among students. Along the same lines, most of the public school superintendents who were interviewed or who participated in groups were frank about living in dread of student suicides and feeling quite helpless about the issue.

➤ According to key informants, access to mental and behavioral health services is a much smaller problem than that of sustaining care for a sufficient period of time to yield positive therapeutic outcomes.

➤ Stigma was cited in focus groups, both adult and youth, as a key and universal barrier to accessing mental and behavioral health services. It had very concrete parameters. Many people cited the difficulty of trying to explain to employers that time off, paid or unpaid, is necessary in order for the former to access mental or behavioral health services.

➤ Key informants and focus group participants struggled with use and abuse issues related to Alcohol, Tobacco, and Other Drugs (ATOD). Adult focus group participants were somewhat fatalistic about the use of alcohol and even marijuana by youth, but the consensus was, among all groups and most informants, that the explosion of available substances, not all of which are controlled or illegal, has made prevention increasingly important, especially among youth. Most participants also cited a continuing problem with alcohol consumption among adults and youth.

Introduction: Research and a Definition of Mental Health

In October of 2013, The Lutheran Foundation contracted with Praxis Strategies & Solutions Inc. to conduct a mental health needs assessment within its 10-county service area: Adams, Allen, DeKalb, Huntington, Lagrange, Noble, Steuben, Wabash, Wells, and Whitley. In the course of strategic planning, the Foundation concluded that it should focus its resources on mental health. The needs assessment was to serve as the vehicle through which the strategic priority, mental health, would become more closely delineated and specified—the basis for translating strategy into tactical and logistical action.

This document is the first of two. It presents the most salient findings of the needs assessment research. The second document is a companion piece and presents the research in greater depth and detail.

A functional definition of mental health is necessary. Praxis asked adult focus group participants and key informants to define mental and behavioral health. The majority described mental health as an ability to deal with different situations and problems in a healthy manner. Definitions of behavioral health included normative actions that align with social expectations and that occur within the boundaries of broadly accepted responses to stressors.

Respondents made a distinction between how one deals with adversity and how one is treated by the world. They saw mental and behavioral health as a complicated set of interactions—not quite a continuum—among brain chemistry and structural wiring, social circumstances, learned or modeled behaviors, and the application of behaviors to specific conditions, events, or imperatives.

The overall view of the respondents aligns with "positive psychology" in its emphasis on the ability of individuals to function in their environments and to build relatively content and productive lives. It is this view that underlies this mental health needs assessment.

Methodology

Praxis proceeded with the needs assessment in a methodologically rigorous, if not traditional, manner. We reviewed the mental health literature, looking at recent empirical and analytical pieces published in refereed journals by neutral research foundations and neutral public sector agencies in their publications. Using the 2010 Census and other demographic data, we completed an environmental scan of the 10 counties that The Lutheran Foundation serves in order to describe the variables impacting on mental health and to develop a contextual framework for the analyses. We constructed an *asset map*: a heat map showing the distribution of mental health services throughout the 10-county area, the types of services available, the density of populations surrounding those services, and the substantive expertise of each service organization. The asset map visually presents gaps in service.

Praxis captured primary data, both qualitative and quantitative, using various mechanisms:
- A randomly selected and demographically representative household survey ($n = 400$);
- A randomly selected survey of youth ($n = 281$);
- A targeted survey of K-12 schools, both Lutheran and others ($n = 129$);
- A primary care physician survey ($n = 25$);

> ➢ Key informant interviews (*n* = 76);
> ➢ Adult focus groups; and
> ➢ Youth focus groups.

Praxis aligned all of the data collections tools so that findings maintained continuity across all exercises and samples. The respondents within each of the components of the research effort were kept discrete so that a survey respondent could not also participate in a focus group, for example. Discreet sampling simply avoided any risk that the experiences of any particular person, geography, or population would skew data.

Household Survey

Praxis conducted a survey of 400 households within The Lutheran Foundation's service area. The survey, a phone interview, was carried out through random digit dialing, with 85% of the respondents contacted on traditional landlines and 15% on cell phones. The survey instrument drew validated questions from the Communities That Care Survey, the Kessler Psychological Distress Measure, SAMHSA (Substance Abuse and Mental Health Administration) National Outcome Measures (NOM), and the Community Assessment Inventory (CAI)—all of which are open-source tools. Embedded in the survey was the Massachusetts General Strengths and Difficulties Questionnaire (SDQ), a validated tool for assessing the mental health status of children and youth often used by pediatricians, school counselors, school social workers, parents, and kids themselves. We embedded the SDQ series in an attempt to gauge parents' perceptions of their children's mental and emotional states. We only asked those adults who indicated that they had dependent minors of school age, specifically elementary and middle or junior high school youth, living in their households to respond to the SDQ.

Praxis established demographic targets for the distribution of response in order to make certain that the sample reflected the distribution of the population in The Lutheran Foundation's service area. Figure 1 lists the targets and the actual respondents interviewed.

Figure 1. Community survey targets and final distribution.		
Age	**Target**	**Actual Count**
20-29	72	72
30-39	72	72
40-49	76	76
50-59	80	80
60-69	28	52
70-79	28	28
80+	20	20
Any Age	24	
Total	400	400
County	**Target**	**Actual Count**
Adams	20	20
Allen	208	208
DeKalb	24	24
Huntington	24	24
Lagrange	20	20
Noble	28	28
Steuben	20	20

Wabash	20	20
Wells	16	16
Whitley	20	20
Total	400	400
Race/Ethnicity	**Target**	**Actual Count**
Black	40 (25 from Allen)	36
Hispanic/Latino	30 (16 from Allen)	25
Asian/Pacific Islander	20 (6 from Allen)	11
Household Income	**Target**	**Actual Count**
Less than $50,000 annually	200	201
More than $50,000 annually	200	199
Gender	**Target**	**Actual Count**
Male	200 (+/- 1%)	200
Female	200 (+/- 1%)	200

The net sample adhered to the targets and was representative of the 10-county service area as a whole. The survey achieved a confidence level of 95 with an interval of 4. It is important to remember that the confidence level decreases when analysis travels along county lines simply because of the small populations sampled. The data are more indicative than definitive when looking at specific counties but generalizable when looking at aggregate phenomena.

Youth Survey
Like the household survey, the youth survey was conducted on the phone, but at first exclusively on landlines. The sample was targeted, ensuring that the randomly dialed numbers reached households that had a high probability of having at least one high school student in residence. In order to comply with the standard of informed parental consent, research technicians conducted a two-pronged interview. A head of household had to affirm that he or she was the parent or guardian of a high school youth living in the household and give consent for that youth to respond to the survey. Once consent had been acquired, the youth either completed the survey immediately or received a callback. If the responsible adult offered his or her son or daughter's cell phone number, interviewers would reach youths at that number. The Boys Scouts pioneered this method of surveying youth in the late 90s.

As with the household survey, the youth survey employed targets that paralleled the distribution of youth across the counties and that aligned with public school enrollments in those counties. Where we originally anticipated 300 completes with the youth survey, we received 281. Figure 2 lists the targets and the results.

Figure 2. Youth survey targets and final distribution.		
Class Level	**Target**	**Actual Count**
Freshmen	75	68
Sophomores	75	87
Juniors	75	70
Seniors	75	56
Total	300	281
Gender	**Target**	**Actual Count**
Male	200 (+/- 2)	141
Female	200 (+/- 2)	140

School Survey
Praxis invited K–12 school representatives to complete an online survey regarding the mental health services available at their schools or in the surrounding community, barriers to accessing services, and the prevalence of particular mental health problems or stressors among their students. We administered the survey separately for Lutheran and non-Lutheran schools, with 69 and 60 respondents respectively. Non-Lutheran schools included public, charter, private, and denominational or parochial schools.

Respondents included principals, assistant principals, teachers, and school nurses, counselors, social workers and psychologists. Respondents were reasonably well distributed across the counties based on population. We did not receive any responses from schools in Steuben or Whitley Counties.

A majority of respondents from Lutheran schools were teachers (62%). Other respondents included principals and assistant principals, school nurses and counselors, administrative staff, and pastors from affiliated congregations, as well as individuals serving multiple roles. 78% of all respondents reported being at schools in Allen County. The remaining responses were from Adams (12%), Noble (8%) and Wells (2%) Counties.

Respondents for both groups were experienced working with youth. 72% had been in their position for 4 or more years and 23%, for more than 15 years.

Physician Survey
Praxis sent 700 surveys via 1st class mail to primary care physicians within The Lutheran Foundation's service area. Physicians were provided paper surveys and a self-addressed, postage paid return envelope. They received a letter explaining the research and encouraging them to share the survey with colleagues, physician assistants, case managers, nurse practitioners and group managers. The letter also included a web link they or their associates could use to respond to the survey. Twenty-five (25) primary care practitioners responded.

Although the response rate among physicians or their professional colleagues is modest, it is important to understand that the more homogenous the demographic characteristics of a population, the fewer respondents need to be in a survey sample in order for the results to have meaning. In this case, the singular demographic—primary care providers—is deterministic in a way that gender, race, ethnicity, or geography are not. Given the homogeneity of the characteristic, the responses are indicative of the experience that primary care providers have with mental health issues.

Key Informant Interviews
Key Informant Interviews were conducted among individuals who are decision-makers, policy-makers or opinion leaders by virtue of their organizational affiliation, not by virtue of their status or perceived power within their respective communities. The interviewees constituted a closed or targeted sample, people specifically and purposefully chosen because of their exposure to and presumed ability to synthesize varied experiences and interests of relevance to this assessment. Their organizational affiliation and their positions within those organizations qualified them as interviewees, not their status *per se*. All of the interviewees' organizations are epicenters within

their respective communities; they sit at social and economic intersects and, as such, influence the flow of people, resources, organizations, goods, services, and programs.

Praxis and The Lutheran Foundation identified key informant prospects jointly. They included 207 individuals distributed across all the counties in The Lutheran Foundation service area. The Lutheran Foundation extended a written invitation to all of the prospects and Praxis followed-up by scheduling appointments. The interviews were conducted in person and on the phone. Toward the close of the key informant process, individuals with whom we could not schedule an interview received an email invitation to respond to the questions on line. Praxis staff interviewed 65 people one-on-one, and an additional 11 people responded to the online query.

Praxis's research team captured interviews from executives from agencies serving the entire 10-county area and from others who focused on local or community services. The interviewees included school superintendents, business representatives, community foundation staff, chambers of commerce, executives at veterans' services, command officers within law enforcement, public health officers, hospital and nonprofit executives, and United Way executives.

Interviewers used a consistent protocol for all interviews to ensure continuity across responses and probed for depth and specificity. The protocol, aligned with all other data collection instruments, covered the prevalence of mental/behavioral health and substance abuse problems, as well as mental and behavioral wellness and protective factors. The interviewees also had the opportunity to discuss the types and quality of services available in their communities. Moreover, we asked them to provide suggestions as to what programs or initiatives would be of the most value to their communities.

Focus Groups
Focus groups are a form of qualitative research in which a group of people are asked about their perceptions, opinions, beliefs, and attitudes towards a product, service, concept, or issue. Questions are asked in an interactive group setting where participants are free to talk with other group members.

Praxis researchers conducted separate focus groups with adults and with youth in grades 8 through 12. We also conducted separate adult focus groups targeting Hispanics and Blacks. A bilingual professional staff member fluent in Spanish facilitated the Hispanic group. Participants were recruited through random calling to households. Youth groups were dependent upon adult groups, with those households that had young dependents in them being asked for permission to screen and invite youth to a separate but collocated and co-scheduled group. The collocation and scheduling made it possible for parents and their children to travel together in the case of face-to-face groups and to schedule their activities accordingly. Groups were held in person and via conference calling. Groups that were originally scheduled for weekdays failed almost universally, with only a few participants showing, and at least 5 groups had to be re-recruited. Ultimately, groups held on weekends proved successful, as did groups using a conference call option. Residents from all 10 counties participated once recruited.

Environmental Scan: Demographics

Population

Figure 3 presents the total population of each county in the 10-county service area. Allen County is by far the largest, with a population only slightly smaller than the remaining nine counties combined. The counties outside of Allen average roughly 36,000 people, with DeKalb and Noble counties slightly higher and Wells County slightly lower.
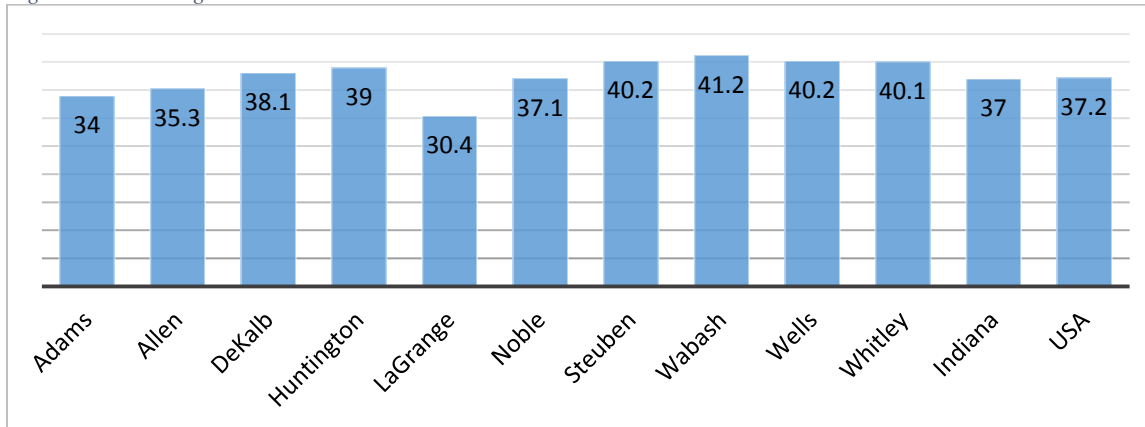
Figure 3. County population.
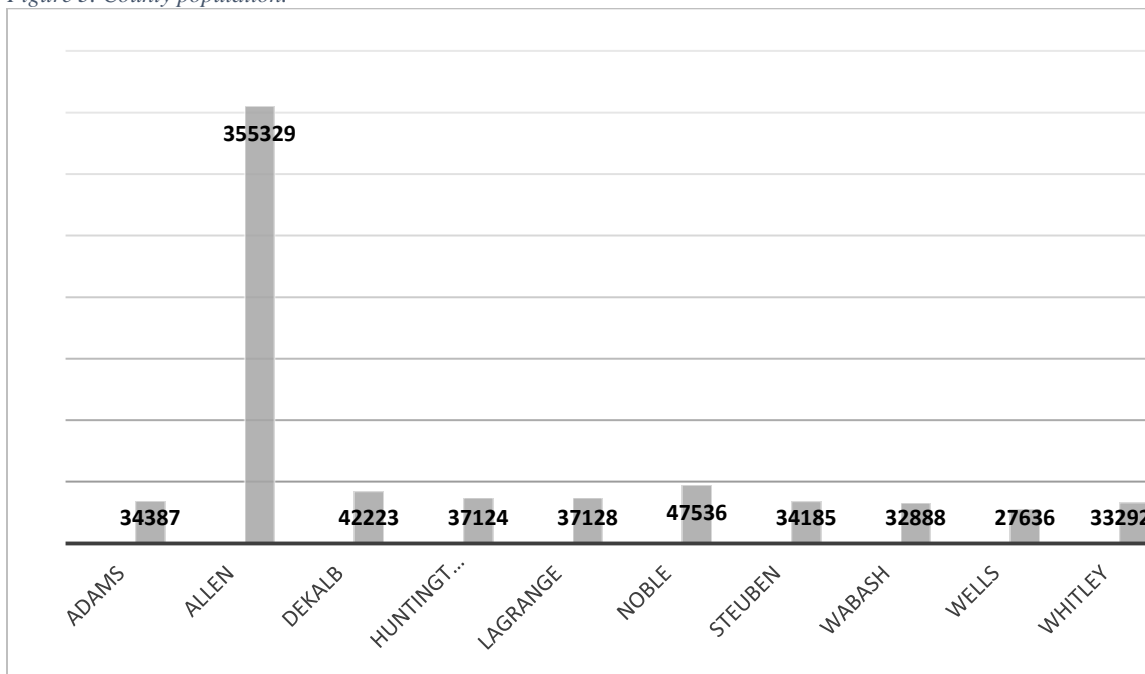
Source: U.S. Census Bureau, 2010 Census

Age

Indiana's median age is slightly younger than that of the nation as a whole. Within The Lutheran Foundation area, six of the counties exhibit a higher median age, which is typical of non-urban areas, as seen in Figure 4. DeKalb, Huntington, Steuben, Wabash, Wells, and Whitley all have a median age that is older than both the national median age and Indiana's median age, though in DeKalb median age variance is less pronounced. Of the remaining four counties, Noble County's median age aligns with Indiana's but Allen County's is somewhat younger, which is typical of more urban areas. Adams and LaGrange counties are noteworthy for their much younger populations. The Median age in these two counties are 3 years (Adams) and 6.6 years (LaGrange) respectively below Indiana's median age.
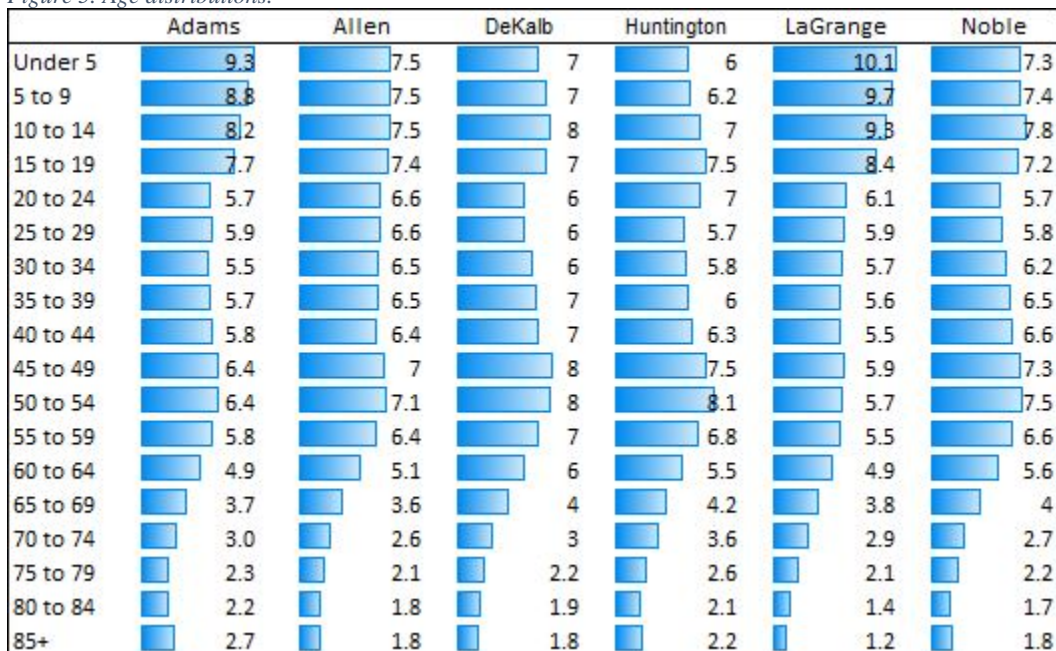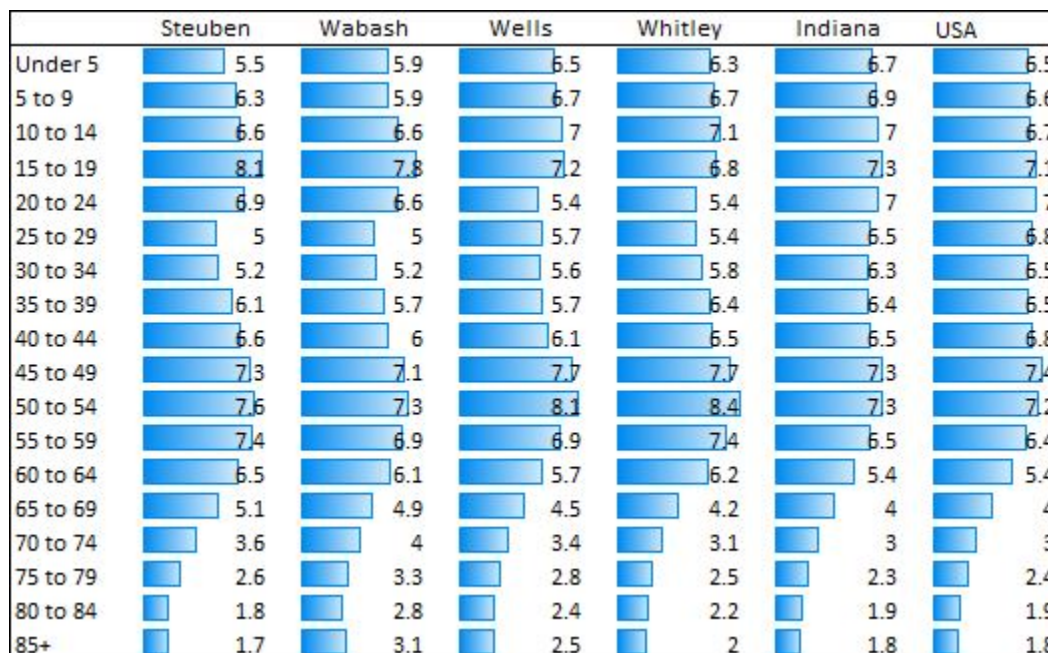
Figure 4. Median age.

Source: U.S. Census Bureau, 2010 Census

When broken down by age group, differences in the composition of each county become apparent. Figure 5 shows the population of each county in five-year ranges as a percentage of the total. Allen County shows the same relative distribution as Indiana and the Nation as a whole, with population swells representing the baby boom generation in the 40-64 year old range, and another in the 10-24 year old range. Most of the other counties exhibit higher percentages in the baby boom range and lower percentages in the younger ages, suggesting that *their populations are statistically aging*. Again, the notable exceptions are Allen and LaGrange counties. In LaGrange County, the adult population is flat, with a steadily increasing population below the age of 19. Significantly, Adams County follows the same, but less pronounced, pattern.

Figure 5. Age distributions.

	Adams	Allen	DeKalb	Huntington	LaGrange	Noble
Under 5	9.3	7.5	7	6	10.1	7.3
5 to 9	8.8	7.5	7	6.2	9.7	7.4
10 to 14	8.2	7.5	8	7	9.3	7.8
15 to 19	7.7	7.4	7	7.5	8.4	7.2
20 to 24	5.7	6.6	6	7	6.1	5.7
25 to 29	5.9	6.6	6	5.7	5.9	5.8
30 to 34	5.5	6.5	6	5.8	5.7	6.2
35 to 39	5.7	6.5	7	6	5.6	6.5
40 to 44	5.8	6.4	7	6.3	5.5	6.6
45 to 49	6.4	7	8	7.5	5.9	7.3
50 to 54	6.4	7.1	8	8.1	5.7	7.5
55 to 59	5.8	6.4	7	6.8	5.5	6.6
60 to 64	4.9	5.1	6	5.5	4.9	5.6
65 to 69	3.7	3.6	4	4.2	3.8	4
70 to 74	3.0	2.6	3	3.6	2.9	2.7
75 to 79	2.3	2.1	2.2	2.6	2.1	2.2
80 to 84	2.2	1.8	1.9	2.1	1.4	1.7
85+	2.7	1.8	1.8	2.2	1.2	1.8

	Steuben	Wabash	Wells	Whitley	Indiana	USA
Under 5	5.5	5.9	6.5	6.3	6.7	6.5
5 to 9	6.3	5.9	6.7	6.7	6.9	6.6
10 to 14	6.6	6.6	7	7.1	7	6.7
15 to 19	8.1	7.8	7.2	6.8	7.3	7.1
20 to 24	6.9	6.6	5.4	5.4	7	7
25 to 29	5	5	5.7	5.4	6.5	6.8
30 to 34	5.2	5.2	5.6	5.8	6.3	6.5
35 to 39	6.1	5.7	5.7	6.4	6.4	6.5
40 to 44	6.6	6	6.1	6.5	6.5	6.8
45 to 49	7.3	7.1	7.7	7.7	7.3	7.4
50 to 54	7.6	7.3	8.1	8.4	7.3	7.2
55 to 59	7.4	6.9	6.9	7.4	6.5	6.4
60 to 64	6.5	6.1	5.7	6.2	5.4	5.4
65 to 69	5.1	4.9	4.5	4.2	4	4
70 to 74	3.6	4	3.4	3.1	3	3
75 to 79	2.6	3.3	2.8	2.5	2.3	2.4
80 to 84	1.8	2.8	2.4	2.2	1.9	1.9
85+	1.7	3.1	2.5	2	1.8	1.8

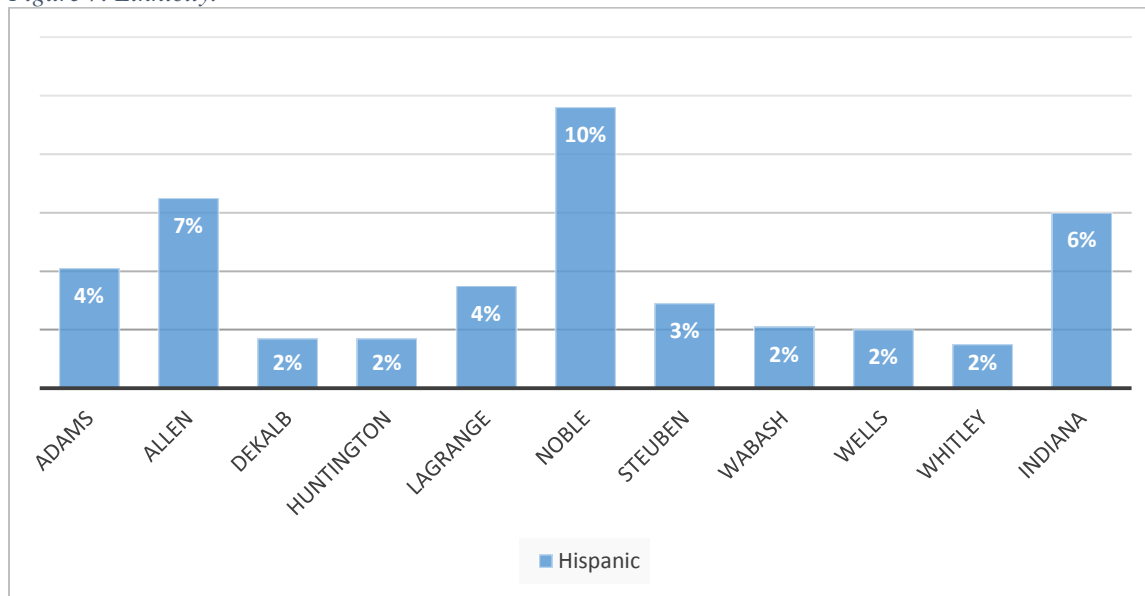Source: U.S. Census Bureau, 2010 Census

Race and Ethnicity

As is true of Indiana, the population of The Lutheran Foundation service area is predominantly White. Only Allen and Noble counties have sizable minority populations. In Allen County, 12% of the residents are Black and 3% are Asian. In Noble County, 5% describe themselves as "Some Other Race". The remaining counties are at least 97% White. Each county also has at least a small Hispanic population, but here again Allen (7%) and Noble (10%) counties have the largest population of Hispanics proportionally. The racial and ethnic populations are shown in Figures 6 and 7.

Figure 6. Race.
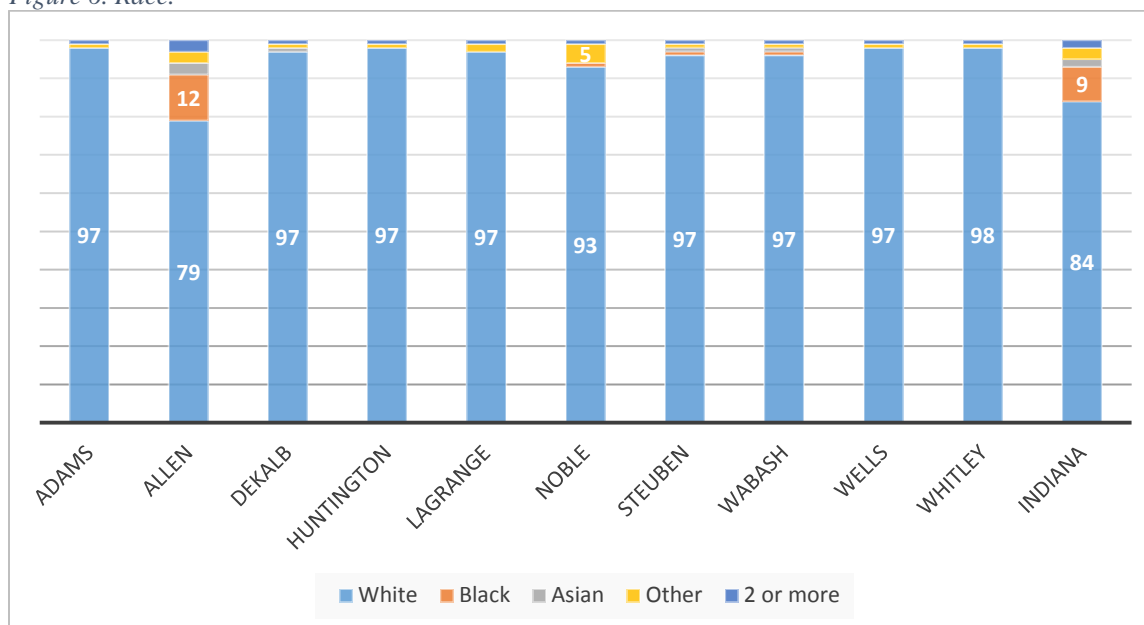
Source: U.S. Census Bureau, 2010 Census

Source: U.S. Census Bureau, 2010 Census

Population Trends

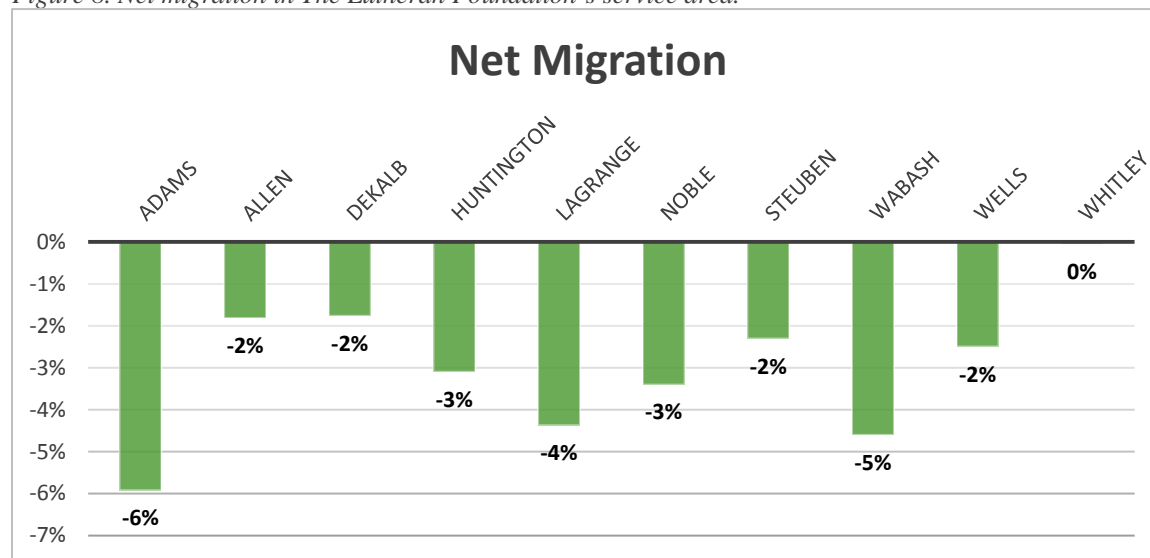Population trends within each of the counties over a 10-year period (2000–2010) are pronounced:

➢ While small, the Black population in Adams County more than doubled over 10 years (2000–2010). In the same period, the population of younger adults has declined. Given the influence of Adam County's sizable Amish population, *the aging of the county is probably more acute than these numbers indicate.*

➢ Allen County's White population has been largely flat in the 10-year period, with population growth driven by increases in minority populations, particularly Hispanics. While the relative growth of the Hispanic population in Allen has been comparable to that of other counties, the size of Allen County makes the increase far more substantial in terms of actual numbers of people.

➢ DeKalb experienced noticeable growth in its small Black and Hispanic communities. However, the population declined in every age group below age 45.

➢ Huntington experienced a decline in total population, as increases in minority populations were not sufficient to offset a decline among whites. Here too the population declined in every age group below age 45. This decline is largely a function of aging baby boomers. However, the precipitous decline in the 0–17 range suggests other factors are also at play.

➢ The population in LaGrange increased in all racial/ethnic groups over the 10-year period. Declines in adults aged 18–44 were modest. Like Adams County, this is probably attributable to the county's Amish influence.

➢ Population change in Noble County was driven almost entirely by Hispanics, who became a relatively large community within the county over the 10-year period. Overall, however, the total population declined in all but the oldest age groups.

➢ Steuben County generally conforms to the pattern seen in other counties: a small but growing minority population, a stable white population, and an older population growing as baby boomers age.

- Like Steuben, Wabash County conforms to the broader pattern seen in other counties: a small but growing minority population, a stable white population, an older population growing as baby boomers age.
- The total population in Wells County has remained almost unchanged, but its makeup continues the by now familiar pattern: growth among minorities and declines among youth and younger adults.
- Whitley County experienced the largest total population growth of any of the counties. All three major racial/ethnic groups grew perceptibly. Aging cohorts, particularly boomers, had the least impact on demographics in Whitley (excluding Allen and LaGrange).

Net Migration

Figure 8 shows the balance of inward and outward migration in The Lutheran Foundation service area over the period 2006–2010. A negative number means more households left the county than moved into it. With the exception of Whitley County, all of the counties experienced more outward migration and, consequently, declined in total population.

Figure 8. Net migration in The Lutheran Foundation's service area.

Source: Missouri Census Data Center, using IRS Migration Files – 2006-2010

As the counties contracted, some populations exhibited significant movement within them. Figure 9 presents the movement of people by race and ethnicity within each of the 10 counties served by The Lutheran Foundation.

The relatively small size of minority populations in most of the counties and their limited representation in the Census Bureau's American Community Survey (ACS) leads to high margins of error. The mobility of the populations presented in Figure 9 is not definitive. They are included only to suggest that small, racial/ethnic communities within the counties may be under considerable strain. For example, even at the lowest end of the survey's confidence interval, the mobility rate of blacks in Adams County is still nearly twice the state's average.

13

Figure 9. Percentage of residents by race/ethnicity who have moved within the same county in the past year.

	USA	Indiana	Adams	Allen	DeKalb	Huntington
White (NH)	7.8%	8.5%	6.2%	7.9%	6.7%	9.3%
Black	12.8%	16.5%	48.4%	14.2%	20.0%	42.5%
2 or more	12.6%	15.0%	9.4%	15.3%	23.5%	7.6%
Hispanic	12.1%	11.8%	18.1%	12.0%	16.4%	15.5%

	LaGrange	Noble	Steuben	Wabash	Wells	Whitley
White (NH)	3.0%	8.9%	7.8%	7.9%	8.2%	6.1%
Black	33.3%	12.9%	8.1%	27.8%	26.7%	25.0%
2 or more	6.6%	21.5%	10.4%	5.1%	13.0%	3.5%
Hispanic	6.6%	22.0%	7.0%	26.9%	25.5%	1.2%

Source: U.S. Census Bureau, American Community Survey 5yr estimates 2007-2011

Households and Families

Figure 10 shows the distribution of household types in each county, Indiana and the U.S. In Adams and LaGrange counties, the Amish skew the results toward more husband/wife families with children. The other non-urban counties have higher percentages of husband/wife families with no children, reflecting the empty nests associated with an aging population. Indiana has a higher rate of single fathers than the nation as a whole. Outside of the Amish counties, this trend holds. The rate of single mothers on the other hand is lower than the state and national figures in every county except for Allen. The percentage of people living alone is also lower than Indiana's and the nation's, except for Wabash and Allen Counties, both of which are higher.

Figure 10. Household type.
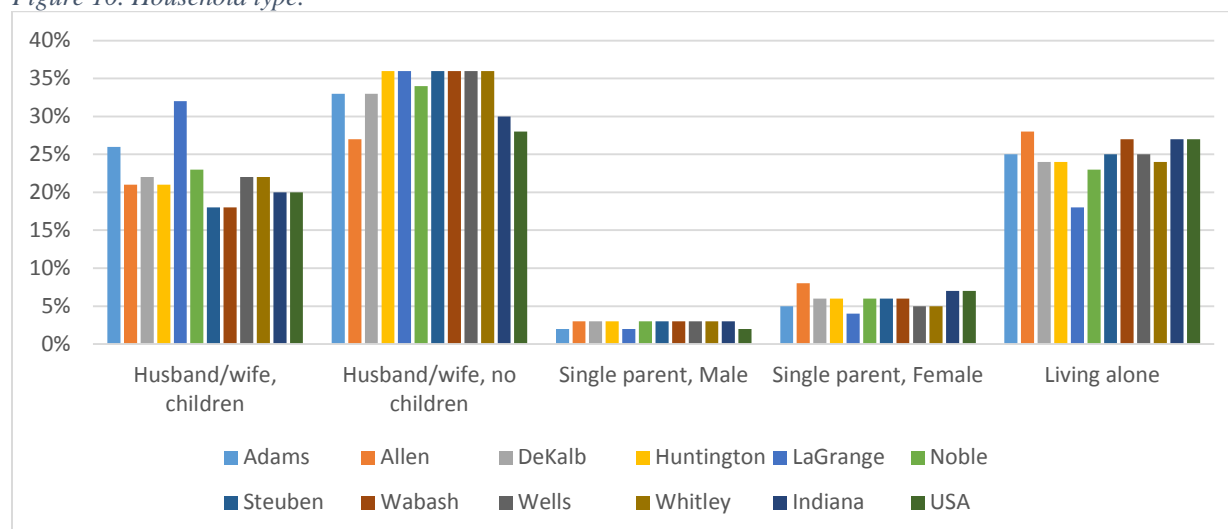
Source: Missouri Census Data Center, 2010 Census data

Figure 11 presents the number of individuals age 65 and over living alone as a percentage of total households. The number of seniors living alone is consistent with each county's median age. However, the percentage in Wabash County is noticeably higher than similar counties with a comparable median age. Adams County also stands out. Despite being the second youngest

county after LaGrange, it has the second highest percentage of seniors living alone. Over the whole 10-county area, among seniors living alone, the ratio of women to men is 3:1.

Figure 11. Seniors living alone.
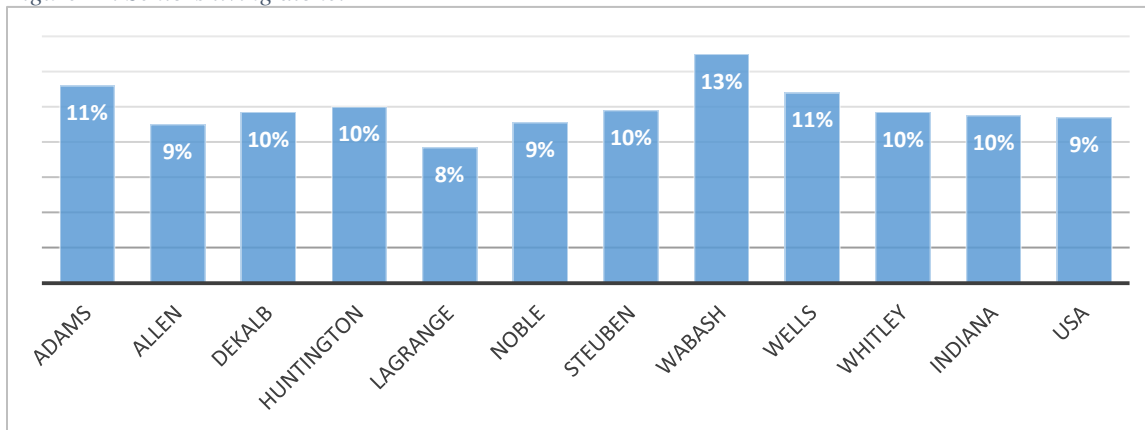
Source: U.S. Census Bureau, 2010 Census

Religion

Concurrent with the U.S. Census, the Association of Statisticians of American Religious Bodies (ASARB) sponsors the U.S. Religious Census, a study of religious congregations and membership. Figure 12 presents the denominational affiliations (by category) of residents in each county, as well as Indiana and the United States. The "Unclaimed" column includes atheists, agnostics, adherents to undetermined sects and denominations, and people who may or may not be spiritual but have no affiliation with a particular denomination.

*Figure 12. Religious affiliation.*
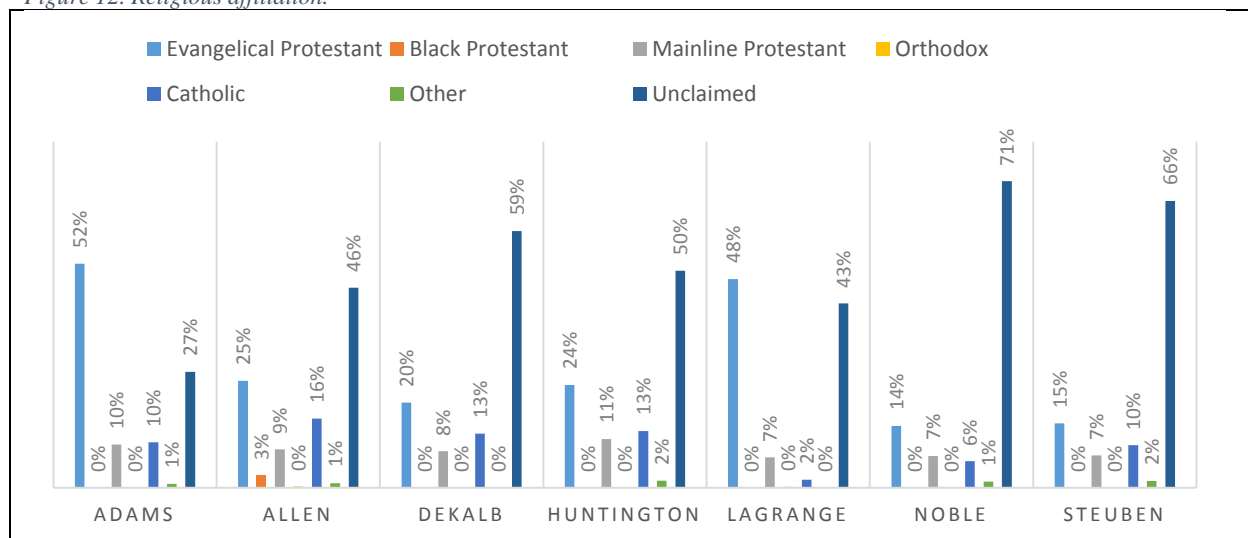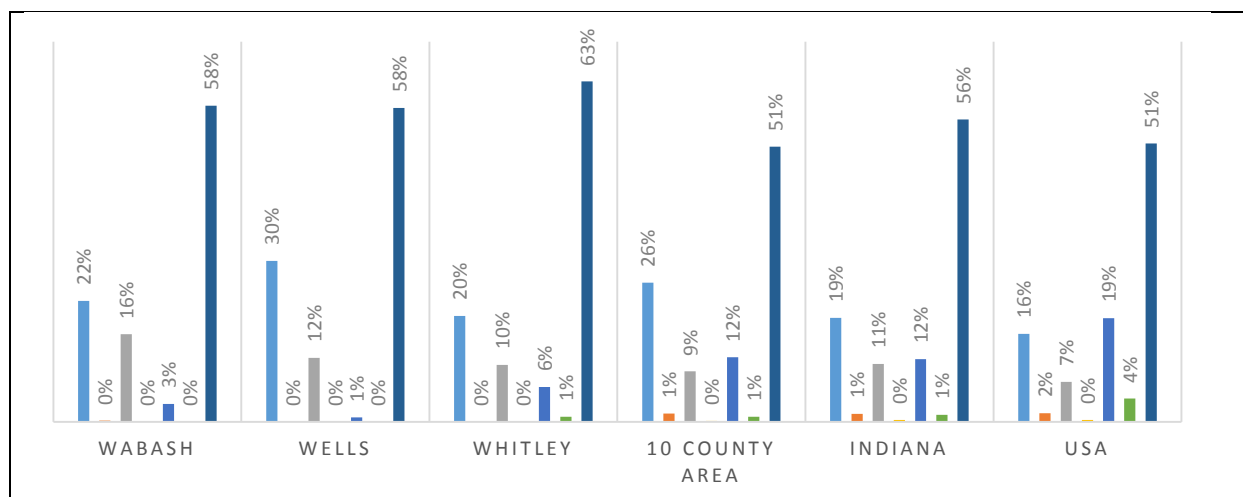
Source: Association of Religious Data Archives, 2010 Religious Census

Religious affiliation in The Lutheran Foundation service area conforms to that of the state—slightly more religious, slightly more protestant, and slightly less Catholic than the nation as a whole. With the exception of Adams and LaGrange counties, where roughly half the population is evangelical protestant, the unclaimed category is statistically the most populated and relatively most preponderant. This lack of affiliation *closes* an important avenue for social support, an important protective factor, especially in non-urban communities.

Veterans

With the exception of Adams and LaGrange counties, the distribution of veterans within The Lutheran Foundation service area is aligned with state and national figures. The lower presence of veterans in Adams and LaGrange counties is likely due to the pacifist beliefs of their large Amish and Mennonite communities.

Figure 13. Veteran status.
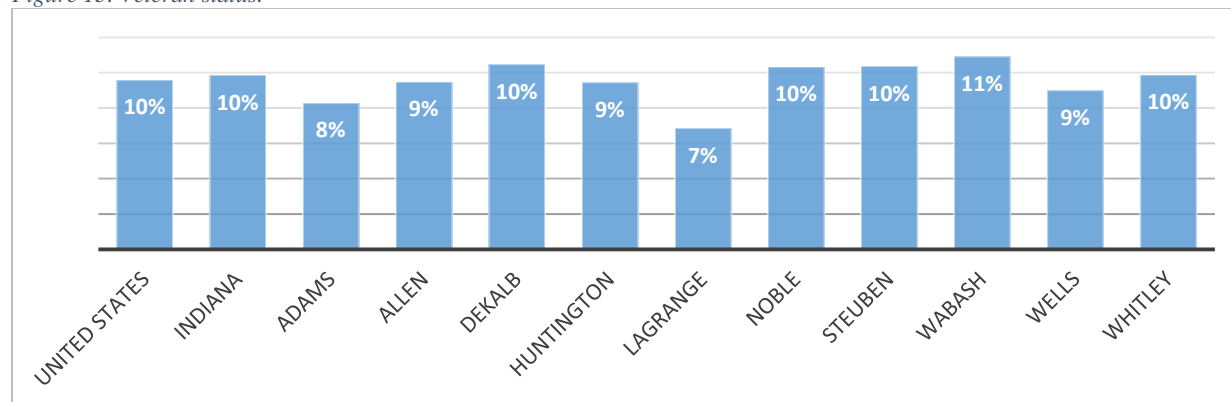
U.S. Census Bureau, 2010 Census

Summary: Demographic Dimensions of Mental and Emotional Health

The environments within which people conduct their daily lives often proscribe their capacity to achieve mental and emotional wellness. The Lutheran Foundation service area is an environment with many stressors and substantive changes afoot. Although change is valuable, or at least inevitable, individuals often find it hard to grapple with the uncertainty it brings.

16

Within the service area, all 10 counties have populations that are contracting, in large part due to significant out-migration. With only two exceptions, the counties are also aging; of note is the tendency for aging residents to live alone, especially aging women.

At the same time that the counties are contracting and aging, most of the counties are experiencing the growth and palpable presence of racial and ethnic minority communities. These "new" populations, at least relatively "new" as rooted residents in the non-urban counties, are highly mobile, moving within their counties to a far greater degree than White residents.

All of the counties have large veteran populations present, many relatively young and requiring support and services. And all the counties, again with the exception of those heavily populated by the Amish communities, have majority populations that do not have religious affiliations. The significance of unaffiliated populations cannot be overemphasized. Organized religion is an important, traditional "protective" factor, which, like others, contributes to community cohesion and provides people with avenues to express and resolve personal and inter-personal issues.

Just on the basis of demographics, The Lutheran Foundation's effort to improve mental and emotional well-being needs to be sensitive to:
  ➢ The needs of aging people, especially those who live alone;
  ➢ The needs of racial and ethnic minorities, especially as they become more present in new communities;
  ➢ The extent to which communities, especially non-urban communities, sustain protective structures, such as religious engagement;
  ➢ The extent to which geographic mobility may undermine the continuity of mental and behavioral care; and
  ➢ The extent to which the significant presence of veterans in most communities poses a unique challenge for mental and behavioral health services.

Dashboard Indicators

The Healthy Communities Initiatives, often conflated with the various Healthy Cities Initiatives, and the Substance Abuse and Mental Health Administration pioneered the concept of dashboard community indicators that, as a set of data, reflect the capacity of communities to support primarily health and well-being. The dashboards became popular in the 1990s. Today, the Healthy Communities Institute sustains the dashboard concept and disseminates it through web-based tools, utilizing both the development of sophisticated technologies and the demanding exigencies of hospital accreditation to market a tool that, at its core, is an agglomeration of secondary data (health outcome disparities, mortality and morbidity rates, suicides, etc.). This observation is not a criticism; it is a compliment. There is great merit in looking holistically at secondary data in order to gain a sense of any given municipality or region's capacity to contribute to or subtract from the health and well-being of residents.

The Youth Behavior Risk Survey, sponsored by the Centers for Disease Control, provides an initial set of indicators, but not on the county level. In the 2011 survey, the last to be released, Indiana youth were statistically more likely than youth in the United States to:
  ➢ Have been bullied on school property during the 12 months before the survey;

- ➢ Have attempted suicide one or more times during the 12 months before the survey;
- ➢ Have suffered an injury, poisoning, or overdose that had to be treated by a doctor or nurse because of suicide attempts during the 12 months before the survey;
- ➢ Have ever tried cigarette smoking, even one or two puffs;
- ➢ Had ever smoked at least one cigarette every day for 30 days;
- ➢ Have ever smoked at least one cigarette every day for 30 days;
- ➢ Have had sexual intercourse with at least one person during the 3 months before the survey; and
- ➢ Have taken diet pills, powders, or liquids without a doctor's advice to lose weight or to keep from gaining weight during the 30 days before the survey. (http://www.cdc.gov/healthyyouth/yrbs/factsheets/index.htm#compare)

The extent to which a community values children or places them at risk suggests the degree to which protective factors promote functional families and mental and behavioral health. Indiana's Department of Child Services (DCS) tracks Children in Need of Services (CHINS). CHINS consists of children who have had DCS interventions on their behalf by virtue of substantiated neglect or abuse. Figure 14 summarizes the incidence of CHINS interventions in November 2013, the last reporting period available.

Figure 14. Children in need of service.

County	Total CHINS	Total Placed in Non-Relative Foster Care	% Placed in Non-Relative Foster Care
Adams	39	15	38
Allen	820	351	43
DeKalb	90	47	52
Huntington	68	31	46
Lagrange	50	10	20
Noble	47	23	49
Steuben	47	22	47
Wabash	103	48	47
Wells	72	30	42
Whitley	36	17	47
Total	1372	594	Average: 43

Source: Indiana Department of Child Services, Practice Indicator Report (http://www.in.gov/dcs/2329.htm)

A single month's data is only a Point in Time Analysis, but it does raise a number of concerns. The actual incidence of child abuse and neglect in the 10 counties served by The Lutheran Foundation is much higher than the DCS data reflects. The incidence of CHINS in DeKalb and Wabash counties is especially noticeable and alarming.

Despite the fact that DCS emphasizes family preservation, large percentages of CHINS are placed in foster care within non-relative households. DeKalb and Noble counties see the highest foster placements of all 10 counties; LaGrange, the lowest.

The Indiana State Department of Health, in collaboration with the Indiana Hospital Association, has created a statewide dashboard of leading indicators of healthy communities. These indicators align with the goals of the Indiana State Health Improvement Plan and Healthy People 2020. This data comes from a variety of surveys, mortality data, and hospital data. Figure 15 (see

following page) presents a few key indicators for counties within The Lutheran Foundation's service area.

Summary: Dashboard Indicators

Family dysfunction, as reflected in CHINS cases, is a problem in DeKalb and Wabash counties. The rate of non-relative foster placements of CHINS suggests that DeKalb and Noble counties see a significant number of children who may suffer long-term consequences from abuse, neglect and placement outside of their immediate families. In Noble County, this could potentially be a consequence of the high teen birth rate. Though most of the counties fair well against the teen birth rate, Noble County, at a rate of 48.3 births per 1,000 teens, is drastically over the state rate of 37.5 and the national rate of 34.2. All but one county (LaGrange) is above the national rate for mothers who smoke during pregnancy-6 counties are over double the national rate.

Indiana and the 10 counties in The Lutheran Foundation service area greatly lag in many of the leading indicators pertaining to or affecting mental and behavioral health. Notably, 6 of the 10 counties are above the state average for the rate of uninsured adults. However, this does not hold true for children under 18.

It is obvious that alcohol is a major issue for the area. The leading indicators defines binge or heavy drinkers as "the percent of adults 18 and older that reported either binge drinking, defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion in the past 30 days, or heavy drinking, defined as drinking more than 1 (women) or 2 (men) drinks per day on average." Most of the counties are 4–5 times higher than the state rate of 4%. The high density of liquor stores in the region also paints a picture of heavy alcohol consumption.

Indiana has a higher rate of Alzheimer's related deaths than the nation. Half of the counties have higher rates than the state, with Noble County having a notably high rate (46.2 per 100,000). Indiana as a whole also has a higher suicide rate than the U.S. average. Adams and DeKalb Counties surpass the Indiana rate.

Demographics indicate some initial prioritization. Allen County, the most densely populated and the most urban area with very diverse communities, requires a great deal of attention. Noble County, with its significant ethnic diversity, also demands some attention, as does Adams. LaGrange is a conundrum, with dashboard indicators that are high, but also containing a large Amish population. LaGrange may need some additional study.

Figure 15. Leading indicators.

County	Adults (%) 18 to 64 who currently lack health insurance	Children (%) under age 18 who currently lack health insurance	Adults (%) who could not see a doctor in the previous 12 months due to cost	Births to teenagers age 15 to 19 per 1,000 females	Births (%) where mother smoked during pregnancy	Adults (%) 18 and older who are current smokers	Adults (%) 18 and older who are binge or heavy drinkers	Controlled substance prescriptions filled and entered into INSPECT per person in the defined region
Adams	23.4%	10.7%	10%	36.9	9.7%	21%	16%	1.15
Allen	25.5%	8.7%	15%	36.5	12.7%	22%	17%	1.26
DeKalb	20.1%	7.2%	10%	34.5	22.8%	22%	11%	1.42
Huntington	18.4%	7.3%	13%	32.2	25.2%	28%	20%	1.59
LaGrange	31.4%	15.4%	15%	28.5	7.5%	22%	12%	0.78
Noble	23.6%	10.9%	13%	48.3	24.0%	28%	17%	1.41
Steuben	20.2%	8.5%	14%	31.6	24.0%	27%	22%	1.33
Wabash	18.6%	7.0%	13%	29.1	25.4%	20%	20%	1.71
Wells	17.3%	6.8%	11%	25.2	15.7%	23%	6%	1.31
Whitley	16.8%	6.8%	11%	31.2	18.3%	22%	22%	1.56
Indiana	20%	8%	17.5%	37.5	17.1%	21%	16%	1.7
U.S.	21.1%	7.5%	16.9%	34.2	9.1%	17%	8%	N/A

| County	Mentally unhealthy days (average) during the previous 30 days	Adults (%) 18 and older without social or emotional support	Alzheimer's disease deaths per 100,000 population (age-adjusted)	Suicide deaths per 100,000 population (age-adjusted)	Violent crimes per 100,000 population	Poverty Rate	Poverty rate for children under 18	Liquor stores per 100,000 population
Adams	2.9	24%	18.2	13.19	N/A	17%	27%	14.6
Allen	3.3	18%	28.3	11.93	257	14%	17%	12.8
DeKalb	3.4	15%	19.6	15.32	N/A	12%	11%	7.1
Huntington	3.0	19%	14.9	9.8	115	11%	15%	13.5
LaGrange	3.6	18%	23.9	6.74	43	16%	23%	10.7
Noble	3.2	23%	46.2	11.42	52	13%	16%	12.6
Steuben	4.7	15%	20.5	11.53	84	10%	16%	17.6
Wabash	3.1	17%	36.1	9.26	101	14%	15%	12.4
Wells	3.4	17%	31.4	8.45	31	10%	11%	10.8
Whitley	1.9	14%	30.7	9.02	46	8%	7%	12.0
Indiana	3.6	19.1%	26.7	12.37	345.7	15%	19%	11.5
U.S.	N/A	19.6%	23.5	11.26	386.9	15%	19%	9.3

Source: All except suicide rates: Indiana State Department of Health and Indiana Hospital Association. Indiana Indicators. www.indianaindicators.org. Suicide rates: Center for Disease Control.

The Geography of Mental Health Services

According to the United States Health Resources and Services Administration (HRSA), there are shortages of mental health professionals in every county in The Lutheran Foundation service area except Allen (http://hpsafind.hrsa.gov/HPSASearch.aspx). Additionally, HRSA classifies Huntington as a medically underserved area (MUA) with respect to mental health. Adams, Allen, and Wabash contain medically underserved populations with respect to mental health (http://muafind.hrsa.gov/index.aspx).

The distribution of mental health services that employ psychiatrists, child psychologists, or psychologists across the 10-county service area suggests a great deal about the ease with which residents can access and utilize those services. Map 1 illustrates the distribution of mental health services by county. Map 2 shows the distribution of services by 100,000 of the population.

Map 1. Mental health services by county.
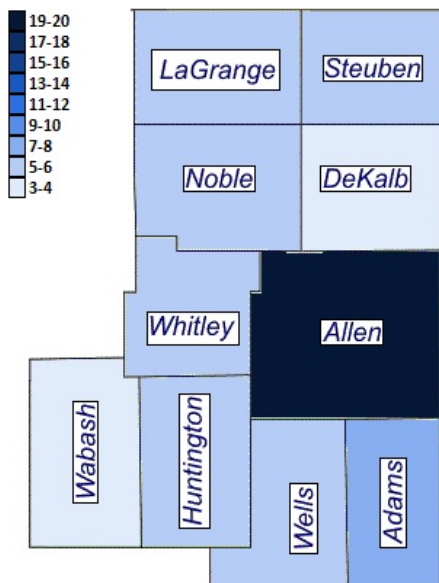
Map 2. Mental health services by population.
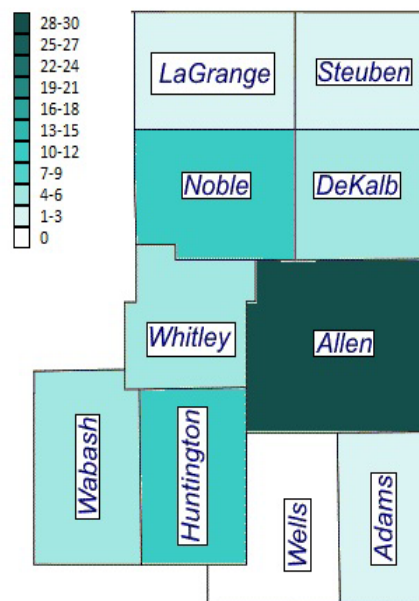
Both maps convey visually what social knowledge assumes intuitively: mental health services are concentrated in Allen County whether those services are viewed from an absolute perspective—the number of services in each county—or from a relative perspective—the number of services by county population.

Key informants valued the initiatives of churches, community centers, and other organizations in providing support for individuals with behavioral and mental health issues, especially in non-urban counties. Nevertheless, most felt that these institutions were underfunded, underinformed, underequipped, and inadequately staffed. There is a strong belief among key informants in rural areas that there is a shortage of qualified service professionals, psychiatrists, child psychiatrists, psychiatric nurses, counselors, etc. in their areas. Access to urban-based medical centers is also

difficult because of the distance from these rural areas to the major service providers and even to smaller, specialized treatment facilities. This lack of access to qualified professionals is reflected in the opinions of many key informants who feel that individuals with behavioral and mental health issues are often misdiagnosed or receive inadequate treatment for their particular condition(s).

Key informants emphasized the need for highly qualified psychiatric specialists, therapists, and counselors able to work with special populations such as immigrants and veterans. They explained that it is difficult to recruit specialists who can meet those needs, more so in rural areas.

Many key informants and physicians in rural counties feel, correctly, that there are insufficient behavioral and mental health service providers in their areas, sharing the opinion that, outside of the major hospitals and health centers in larger neighboring cities, the smaller organizations that offer treatment services do not have the capacity to reach their communities. They identified some of these institutions as inaccessible primarily due to transportation and cost.

Key informants expressed a need for more halfway houses, more supervised residential facilities in general, and more options in types of treatment services. The discussions of alternative treatment included not only utilizing methods like art therapy, but also providing more culturally sensitive treatment, walk-in services, family support, etc.

Key informants and focus group participants almost unanimously agreed that there are not enough service providers offering assistance to families coping with loved ones struggling with behavioral health or mental health issues. In fact, most respondents felt that there were no services of this kind being offered in their communities. The exception was the National Alliance on Mental Illness (NAMI) in Fort Wayne, which was widely praised for the quality of its support services for caregivers and families of individuals with severe mental illnesses. NAMI's scope and reach, however, are proscribed and leave a tremendous void to be filled.

Focus group participants were unaware of any services for families, except through their churches. They also noted a lack of parent education services that help parents to, in turn, help their kids. Similarly, most respondents to the school survey reported that their schools had the ability to provide some form of individual counseling for students, but only a small percentage reported that their school offered counseling for families. The percentage was higher for private or parochial schools but still amounted to less than a third of all schools represented in the survey. Only one in ten reported that their schools provided support or education for parents or caregivers.

Access and Utilization

Key informant interviews, the community survey, the school surveys, and focus groups all concur about the barriers to accessing mental or behavioral health services. The most common responses were lack of information and stigma. Cost, distance from service providers and transportation, trust in service providers, commitment to long-term treatment, and availability of timely services were also frequently cited as barriers to accessing services. The most knowledgeable key informants suggested, however, that access per se was not the only issue.

Sustained therapeutic engagement is actually a major barrier to achieving wellness, they argued. Many people simply "drop out" of their therapies, whether talk or pharmaceutical (or a combination of the two), before they have resolved or learned to manage their issues.

Stigma

In key informant interviews, stigma was one of the most frequently mentioned barriers to treatment of mental and behavioral health issues. Although attitudes toward substance abuse, particularly alcohol, tobacco, and marijuana, have reportedly relaxed quite a bit, there is still a great deal of stigma around mental health and help-seeking. Informants often associated stigma with pride, explaining that many people are simply too proud to seek professional help for issues that social stigma paints as untreatable weaknesses. Stigma tends to minimize mental and behavioral health issues rather than treat them as important conditions requiring treatment. In focus groups, participants indicated that shame and denial are "huge" barriers preventing individuals from seeking treatment. They expressed their concern with, as one participant put it, not wanting "people to think I'm crazy".

Attitudes toward Mental and Behavioral Health

Attitudes toward mental and behavioral health as defined by adults were scattered. Some would say there is a positive perception of how others view mental and behavioral issues; in this sense communities rally around the issues, forming committees or holding fundraisers and drives to help the cause, concomitantly promoting community cohesiveness and wellness. Most respondents, informants, and focus group participants, however, characterized their communities' attitudes toward these issues in negative terms: ignorant, apathetic, or in denial. Substance abuse tends to be more tolerated or subject to more lax stigma than mental health. Some key informants explained that in some counties attitudes have been shifting in favor of the legalization of marijuana. Even law-enforcement figures in some instances appeared to be rather unconcerned about marijuana consumption but were very concerned with methamphetamine consumption.

Youth's attitudes towards mental and behavioral health were marked by neglect and independence. Many youth try to ignore the issue or just deal with it themselves. Conversely, some informants and focus group participants suggested that youth do occasionally turn to friends, teachers, guidance counselors and family for advice. For many youths, the Internet is a source of information to which they turn when wanting to learn about the mental and behavioral health problems they may be experiencing. In addition, it was discovered that male youth would be less likely to seek help than the female population, and many informants suggested that male youth were at higher risk for developing mental and behavioral health issues than other demographics.

Urban and Non-urban Approaches to Minimizing Stigma

Informants working or living in rural communities stressed the importance of the stigma around mental and behavioral health and were concerned with confidentiality while informants in urban areas argued for increasing access points for services at the community level. Informants in rural areas expressed their sense that many people needing help refuse to seek treatment because the locations of certain treatment centers are too visible to others in their communities. Some interviewees offered somewhat contradictory suggestions for dealing with the issue of stigma;

some felt that service providers in rural communities should locate their centers in spaces removed from the public eye, where those seeking services do not run the risk of being identified or recognized by peers in their communities. Informants in larger metropolitan areas recommended adding more small clinics specially designed to treat low-income and immigrant populations in more communities. Both rural and urban informants advocated promoting services with an emphasis on the normalcy and benefits of help-seeking, "normalizing mental illness." The physicians surveyed saw shame as being a major barrier to seeking services. In focus groups, youths suggested that, to ensure children and adults have access to quality mental and behavioral health and substance abuse treatment programs, the county should make mental health or emotional health seem like a normal thing. Adding that people shouldn't feel like they are the only ones with these issues.

Cultural Specificity
While interviewees widely cited the stigma associated with mental health problems as one of—if not the most—substantial barriers to treatment, focus groups with both youth and adults revealed how pervasive that stigma is, and how it can manifest itself in very culturally specific ways. For example, for those who enjoy an outdoor sportsman lifestyle of hunting and fishing, fear of being labeled "mentally ill" and being banned from purchasing a firearm discourages individuals from seeking help. The ideal of rugged individualism and an ethos of self-sufficiency lend further discouragement. Among certain groups, a pervasive mistrust of government generally places any agency with any government connections under a pall of suspicion.

Many immigrant communities reportedly perceive mental and behavioral health issues as threats to immigrants' likelihood of successfully integrating themselves into American society. One key informant explained that in some countries mental health issues could get you "locked-up," adding that foreign cultures have different ways of thinking about health; immigrants may not even understand or acknowledge behavioral and mental health because the concepts are foreign to them.

Information
Concern over access to information regarding treatment and support services is widespread throughout the 10 counties considered. Respondents, focus group participants, and key informants frequently stated that people do not know where to go or are uninformed about how to tell if someone needs help and how to go about helping that person get the assistance they might require. There is a lack of awareness of what mental and behavioral health issues entail and the services out there that address mental and behavioral health needs. Focus group participants indicated a general lack of awareness of what a mental health problem is, what it looks like, and what symptoms to look for. They spoke of the difficulty in distinguishing between a "down spell" which they felt they could handle, and something that crosses the line into an actual mental health problem. In focus groups, most youth were unaware of any counseling or mental health services available in their county. A few youth mentioned Alcoholics Anonymous, Park Center, Rescue Mission and Carriage House when asked *"Where do people go to get help with substance and addiction problems?"* Responses varied from seeking the guidance of parents, family, friends, teachers, student groups, counselors, principals, and speakers to listening to the positive influences of "Say no to drugs" and other campaigns warning youths about the harmful effects of drugs.

Providing Information
In key informant interviews, interviewees frequently stated that there was a lack of information (or informational materials) in circulation about mental and behavioral health services. In some counties where substance abuse is a major concern, there are plenty of advertisements about substance abuse prevention and recovery. However, most interviewees felt that people were generally undereducated or ill-informed about mental health issues in particular and the services and resources that are available to assist with both mental and behavioral health problems.

Few key informants mentioned avenues for reaching senior citizens, outside of church organizations and underutilized community centers. Because of an assumed tendency for many seniors to be isolated from their communities or neglected, providing them with information can be a challenge. Outreach targeting this demographic should be a priority in any efforts aimed at promoting mental and behavioral health service.

Referral Services
According to key informants, referral services, like United Way's 211, are underutilized. Moreover, many referrals reportedly come from the court system and law enforcement agencies; although, these are invaluable agents for directing individuals to the treatment they require, the association drawn between criminality and mental and behavioral health services strengthens social stigma. With this in mind, efforts to reach and inform the public must be coupled by rhetorical considerations aimed at lessening social stigma around the issues.

Facilitating the Transmission of Information
Many hospitals and other service providers have outreach initiatives in action, including advertising via billboards and radio, television, and print media. These providers, not to mention private medical and mental health practitioners and organizations like Veterans' Affairs, halfway houses, et al., play important roles in the transmission of information and in referral processes. However, non-profit service providers or underfunded programs reportedly have difficulty promoting their services outside of the communities in which they are based due to a lack of financial resources. Many respondents felt that service providers needed to form a stronger referral network, working with hospitals, organizations, and insurance agencies to help individuals in both remote rural and isolated urban areas, for example immigrant communities, find the services they require.

In communities with largely immigrant populations, the language barrier, in addition to other cultural differences, makes providing culturally appropriate information in the target language difficult to achieve. Some informants reported that a few of the major service providers have initiatives in place to address this problem, such as interpreters in hospitals, but many indicated that there is a lack of culturally sensitive services to which to refer immigrants suffering from mental and behavioral health issues. In rural communities, getting information to individuals can be a challenge due to the scattered population, but according to key informants coordinating marketing can be easier because there are fewer players to engage. For example, a rural county might only have a single newspaper or radio station; it stands to reason that engaging these fewer entities may prove easier than reaching a great number of media outlets. Focus group participants

also noted a tendency to refer to the Internet and self-diagnose, and that people may think they don't need professional help.

Providing better information for people to know what to do if they have a mental or behavioral health problem was widely heralded as one of the most important steps that needs to be taken. Media campaigns were a frequent suggestion, though a number of key informants were skeptical that such campaigns would accomplish anything at all, explaining that people tend to ignore these ads until they develop a problem for which they need help with. So, while such campaigns might temporarily raise awareness and may be conducive to reducing stigma, they would be of little benefit in terms of helping people access or navigate the system.

Schools and churches are seen by many key informants and focus group participants as venues for transmitting information directly to youths and families, but many respondents indicated that school faculty, clergy, and others are ill-informed themselves and require training for how to adequately refer individuals to appropriate service providers. Respondents to the school survey also felt that these individuals frequently did not have adequate training or experience. Employers are also seen as a valuable—though uninformed—medium.

Cost

Key informants and physicians from rural communities indicated that financial difficulties are also an important barrier preventing people from receiving the treatment they require. Many people in these communities simply cannot afford treatment services. Even those who are insured have a hard time shelling out co-payments and are often prescribed medications that they cannot afford to stay on for an extended period of time.

In focus groups, financial concerns were cited as a substantial barrier. Availability of services was often tied to cost; participants indicated that services are indeed available, but only if one has the means to pay for them. They described a sort of cost/benefit analysis: when deciding whether or not to seek help, people have to decide if the potential benefits of treatment are worth the money—typically the answer is no. It was noted, however, that many just assume that treatment will be expensive without any knowledge of the actual cost or of what assistance may be available.

Transportation

Several key informants explained that individuals with dependence issues often have limited access to transportation, many because their licenses have been suspended or revoked due to DWI or OUI charges. Public transportation is limited in rural areas, which makes it difficult for people in these areas to commute to the major treatment centers.

Focus group participants from rural areas attested to the difficulties faced by rural populations in getting from place to place; they added that since there aren't many places to go locally to begin with, people become hopeless and feel that help is out-of-reach. Several participants and interviewees noted that a majority of the services—especially specialized services—tend to be in the Fort Wayne area, which could be over an hour away depending on where you live.

Trust

A sense of trust regarding the service provider is a key determinant of an individual's willingness to seek help for a mental health issue. Focus group participants named an array of negative consequences resulting from being "found out," consequences which discourage them from accessing services. Beyond a generalized apprehension around "what people might think," participants named fear of getting in trouble, particularly for substance abuse issues, fear of losing their jobs, and fear of losing friendships. Youth also feared jeopardizing their future. Because of these potential outcomes, privacy was cited as being very important.

In youth focus groups, participants indicated that they trusted their friends, parents, or certain individuals such as youth pastors, but were fearful of placing trust or sharing their problems with strangers or faceless agencies. Key informants also explained that special populations have difficulty relating to or trusting service providers who are not culturally sensitive to them. Veterans reportedly feel that the civilian world is uncomprehending of and unsympathetic to their needs, while immigrants and minorities may not trust in mental and behavioral health specialists who they feel do not understand their cultural background or who may not speak their language.

Follow-up/ Follow-through

Lack of follow-through, or outright non-compliance, with intervention and treatment was noted as a barrier to service in the school survey. 70% of respondents from non-Lutheran schools indicated student non-compliance as a barrier (34% from Lutheran schools). Lack of follow-through from parents was also noted in open-ended questioning, particularly where the parent also has a mental or behavioral health problem. Cross-generational mental health problems, where parent and child share the same diagnosis, are particularly difficult to manage, as the parent may be unable to help the child due to their own problems, which can in turn worsen the problems of both the parent and the child. Knowledgeable key informants reiterated the problem of continuing care. As one respondent observed, "We can get them in the door. We can even keep them for a while. But we can't make them follow-through with after-care, counseling, medication or anything else they choose not to do."

Inadequate Availability and Commitment to Long-term Treatment

School staff report being overwhelmed to the point that their workload has become a barrier to accessing services at their schools or through other agencies to which school mental and behavioral health professionals may refer students. In Allen County, this was the most frequently cited barrier to mental health services or referrals (93%) in the school survey. Roughly two thirds of respondents cited too many students requiring too many interventions and an insufficient supply of trained or experienced professionals as barriers to service. Of the counselors, social workers and psychologists surveyed, 65% only spend some of their contact time with students addressing mental or behavioral health issues; 20% indicated that it made up most of their contact time. While not as prevalent, insufficient time and integration of services within the school system was also noted as a barrier in many counties.

Key informants working in hospitals, law enforcement, schools, and other organizations providing mental and behavioral health services frequently expressed their concern over a shortage of qualified specialists. In Allen County, law enforcement agents expressed a need for a

dedicated Crisis Intervention Team. School officials also signaled a need for personnel trained in crisis intervention. Several informants in rural areas expressed their concern over a shortage of child psychiatrists, psychiatric nurses, and other qualified mental and behavioral health specialists in their communities. Because so many of these rural communities must seek treatment in neighboring counties and because transportation is a barrier to access, commitment to long-term treatment is a major issue. Several key informants also expressed their concern over a shortage of walk-in services. According to interviewees, people often require immediate attention, especially when suicidal ideations come into play. Thus, accessing services in a timely fashion is an issue. Scheduling an appointment with a mental or behavioral health service provider more often than not requires planning a visit well in advance. Because many people work during normal business hours, it is difficult to schedule appointments with service providers without having to interrupt work schedules. Providing an explanation to employers regarding the reason for requesting leave from work to visit a mental or behavioral health service provider can also be problematic given the stigma surrounding these health issues.

Many individuals suffering from mental illnesses require frequent, long-term counseling and therapy sessions. Most service providers reportedly offer only outpatient services; one informant stated that there are no in-patient treatment options available at all in rural counties. Intermittent treatment is an issue not only as regards mental health, but also addiction recovery. According to key informants, treatment for substance abuse issues typically consists of treating physical symptoms of addiction, neglecting the source of the problem: the patients' dependence. Treatment of this kind offers temporary relief to persons suffering from chronic health issues whose resolution requires commitment to long-term treatment on the part of both the patients and the service providers.

Insufficient Services In or Through Schools

At one level, the prevalence of youth seeking help at school for one issue or another is an indicator of the prevalence of those issues—information on this matter is addressed in the section on prevalence—yet, at another level, it also reflects the perception among youth of the issues or problems with which teachers, counselors or other school staff are able to deal. The student will not approach a staff person if they do not feel that they will benefit from the interaction, and his or her issues will glide below the radar of school officials. Disparities between what problems youth report facing, and what problems they seek help for reveal potential gaps in services available to youth.

In surveys, focus groups, and interviews, schools are frequently seen as the primary service provider for youth, or as the primary doorway into the mental health system, particularly in more rural counties. Broadly speaking, school survey data reveals that the schools deal frequently with academic issues, disruptive behaviors, or the externalized symptoms of a mental health problem; they do not deal as much with internalized problems or with issues that do not disrupt class.

School officials in Wabash County noted that the Bowen Center offers 2 free sessions to students in their districts. The superintendents stated that Bowen Center staff work well with the schools to keep them abreast of the types of mental health and family issues they see with their students. The superintendents of these school districts saw this as a major asset in helping students and

their families connect with much needed services. This level of service was not mentioned by other school districts.

Lack of Coordination/Collaboration

Lack of coordination is not necessarily perceived as a gap in service or as a barrier to accessing service, but as a drag on the quality of the system as a whole and of the services provided, which ultimately results in gaps and barriers. This leads to a reduced capacity to make the appropriate diagnosis and deliver appropriate treatment, thus creating poorer outcomes.

Many informants stated that there isn't a good referral network or good case coordination within their communities. A few people who had been referred to services stated that they did not know where to go or how to get started in the process. This indicates that though some people may be told they should seek help for themselves or a family member, they are not given the proper information on how to go about it.

Adult Mental Health

Physicians responding to their survey noted several mental and behavioral health issues that their patients present. Depression, anxiety, and stress topped that list; however, attention-deficit/hyperactivity disorder, bipolar disorder, self-esteem issues, and substance abuse were also cited. They indicated that they dealt with such issues often or very often. The physicians indicated that they most often treated these disorders or issues with prescription medication. Only half of the physicians referred out to other professionals for assessments or counseling, but did so for only about 10% of their patients. Almost all of the physicians surveyed indicated they refer patients to faith-based organizations for assessment and counseling less than 20% of the time. Most of the referrals from physicians seem to be for issues or services they perceive as formidable and beyond the scope of their expertise—comprehensive mental health assessments and inventories, therapeutic and behavioral counseling, in-patient substance abuse treatment, and suicide assessment and intervention.

In the household survey, adult respondents were asked about symptoms and feelings related to depression and anxiety within the previous 30 days. Sixty-five percent of respondents (n=260) stated they had felt at least one of these symptoms at least a little of the time during the previous 30 days. The most prevalent symptoms were feeling nervous (43%, n=172), feeling restless or fidgety (33%, n=132), feeling that everything was an effort (21%, n=82), and feeling that their physical health problems affected their feelings (27%, n=107). The lesser prevalent symptoms were feeling hopeless (12%, n=44), feeling so depressed that nothing could cheer them up (8%, n=28), and feeling worthless (7%, n=25). Many of the respondents indicated that they had multiple symptoms simultaneously. However, of the 260 people with symptoms, *only 16* said they had seen a doctor or other professional about those symptoms.

Respondents were more likely to see a doctor for symptoms related to anxiety than for symptoms related to depression. There were several statistically significant phenomena regarding symptoms:
  ➢ Those who had felt nervous at least a little of the time in the previous 30 days tended to be younger than those who did not (t=2.2143, p=0.013);

- ➢ Those living with no other adults present tended to feel so depressed that nothing could cheer them up on a statistically higher level than adults living with other adults (t=-2.5177, p=0.0061);
- ➢ Blacks were statistically more likely to feel worthless at least a little of the time than non-Blacks (t=-2.4993, p=0.0064); and
- ➢ Several subgroups felt, at a statistically significant level, that their physical health had been affected by their feelings of anxiety and depression:
  - Those living in Allen county were more likely than those living outside of Allen County (t=-1.8939, p=0.0295) to perceive their physical health as having been affected by anxiety and depression;
  - Those living with no other adults were more likely than those living with other adults to perceive their physical health as having been affected by feelings of anxiety and depression (t=-2.7377, p=0.0032);
  - Non-whites were statistically more likely than whites to report physical health issues related to depression and anxiety (t=1.6989, p=0.0451);
  - Symptomatic respondents tended to have statistically higher incomes than those who were not symptomatic (t=2.4423, p=0.0075);
  - Statistically, those reporting that they felt physical symptoms secondary to anxiety and depression tended to be older than those who did not (t=-3.4327, p=0.0003);
  - Those stating that they felt physically symptomatic tended not be employed full-time (t=3.2148, p=0.0007); and
  - Those stating they felt symptoms tended to be retired and not working (t=4.4628, p=0.000).

According to focus groups and key informant interviews, people tend to believe that the elderly suffer more from depression in response to being lonely and isolated and in combination with physical and mental ailments. A number of respondents felt that a lack of preparedness for aging, coupled with mortality anxiety, affected the mental health of seniors. *Though not found to be significant in the household survey*, several people noted that seniors have feelings of hopelessness possibly as a result of being isolated, feeling forgotten, or their dependence on others.

In 2013, Praxis conducted a mental health needs assessment specifically looking at Indiana's senior population for the Geminus Corporation. The analysis looked at Northwest, Northeast, Central, and Southern Indiana separately. The Northeast region included all 10 counties in The Lutheran Foundation's service area, as well as in the neighboring 12 counties. The results of the current community survey mirror the senior mental health needs assessment analysis. Feelings of nervousness and restlessness, and feelings that everything is an effort and that their physical health affected their emotions were the most prevalent symptoms noted. Seventy-four percent of Northeastern residents stated they felt nervous at least a little of the time in the previous 30 days. Seniors in the Northeast region (25%) had a higher prevalence of feeling that everything was an effort than the other regions.

Special Populations
Special populations such as immigrants, veterans, and inmates experience similar problems with

depression, stress, anxiety, and substance abuse as the general public, perhaps in an even more intense manner. According to those key informants who were knowledgeable of mental and behavioral health issues, conditions like post-traumatic stress disorder were more common in these populations than in the general public. For immigrants, adjusting to life in a new country, coping with cultural and linguistic barriers and differences, loss or grief over separation from loved ones in their homeland, and the stress of having to facilitate the integration of their children or partners into a culture that is foreign to them seriously impacts on their mental health. Many immigrants may have recently experienced violence, oppression, and intolerance in their homeland and do not necessarily have access to culturally appropriate resources in the United States that can help them cope with traumatic experiences.
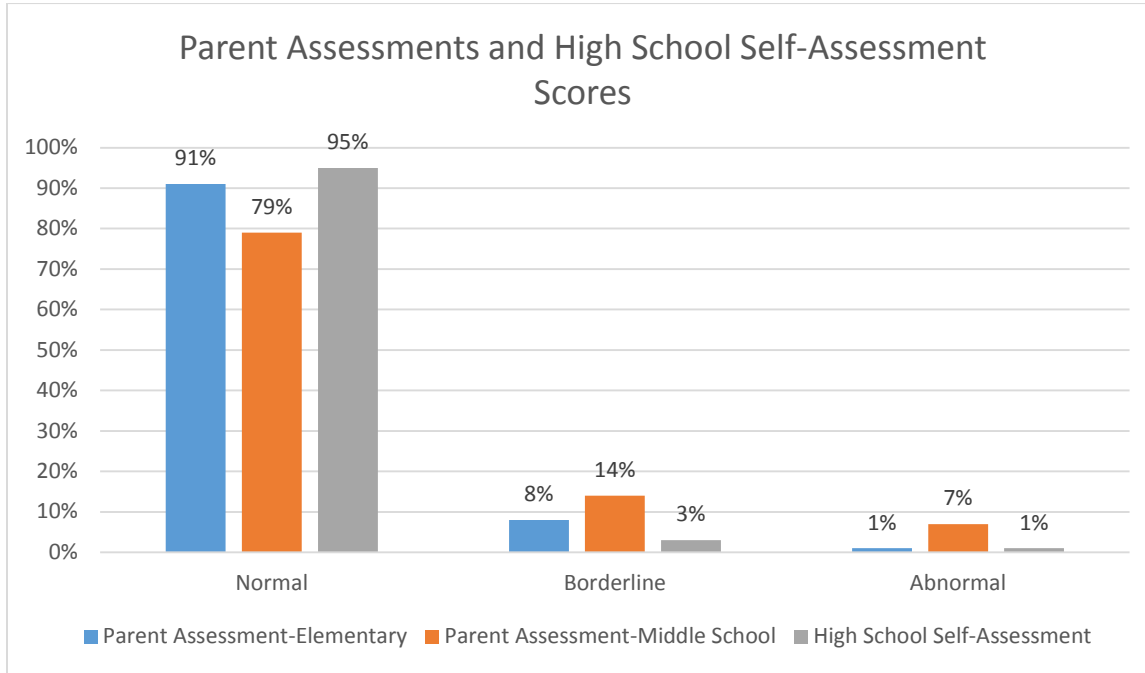
Key informants who deal directly with veterans explained that these individuals tend to have traumas that are not only difficult to live with, but also difficult to treat. Many veterans struggle to re-adapt to civilian life and often have problems finding and maintaining steady employment and keeping up with their financial responsibilities. As with immigrant communities, rates of alcoholism among veterans are reportedly quite high. The only relatively full-service Veterans Affairs Health Center in Northeast Indiana is in Fort Wayne, which can create transportation issues for those who live outside of Allen County and need services.

Sheriffs and law enforcement officials interviewed provided valuable insights into the state of behavioral and mental health among inmate populations. Substance abuse and the side effects of abuse, such as drug-induced psychosis, are common health issues among inmates. Several law enforcement key informants explained that shortages in resources or limitations in infrastructure are barriers to providing adequate treatment for incarcerated persons. Other key informants frequently explained that individuals with mental and behavioral health issues often went undiagnosed or untreated until they entered the court system. One interviewee who works with inmates explained that many factors prevent the jailed population from receiving care, one of them being that service providers simply refuse to treat incarcerated persons. This raises the issue of whether individuals with mental illnesses should be in the jail system at all. It also raises the question of whether or not jails in particular have become the residential mental health facilities of the 21st century. One interviewee, a county sheriff, observed "Jail is not the place for people with serious mental health issues." Another observed that "… mental health [in the United States] hasn't been deinstitutionalized; jails have just become the asylums, but without the money."

Youth Mental Health

The Massachusetts General Strengths and Difficulties Questionnaire was embedded into both the community survey and youth survey. The community survey version asked parents to assess their own children (elementary and middle/junior high aged students were asked separately). Youth responded to a self-assessment version of the questionnaire. The score of this scale places the respondent (or their child) in categories of normal (higher), borderline, and abnormal levels (lower) of functioning. The youth survey was conducted among high school aged youth (281 respondents). A total of 86 assessments were completed for elementary school age range and 87 for middle school by parents. The breakdown of each age group by category is presented in Figure 16. Overall, the scores are better than what would be expected in a random sample. Results of 10% abnormal, 10% borderline and 80% normal is considered typical.

Parent Assessments and High School Self-Assessment Scores

(Values shown in chart)

- Normal: Parent Assessment-Elementary 91%, Parent Assessment-Middle School 79%, High School Self-Assessment 95%
- Borderline: Parent Assessment-Elementary 8%, Parent Assessment-Middle School 14%, High School Self-Assessment 3%
- Abnormal: Parent Assessment-Elementary 1%, Parent Assessment-Middle School 7%, High School Self-Assessment 1%

Legend: ■ Parent Assessment-Elementary   ■ Parent Assessment-Middle School   ■ High School Self-Assessment

Statistical analysis produced few significant results. For the elementary and middle school groups, income was the only variable for which there was sufficient data, but ordered logistic regression indicated no significant difference in categories based on household income (z = -0.64, p = 0.521). For high school students, there was a much larger number of variables in which distinctions could be drawn, but only two significant results were found. Those who agreed that their families do not understand them (x^2=9.2091, p=0.010) and those who agree that people in their community care about each other (x^2=-7.9067, p=0.019) tended to be categorized as normal.

In the school survey, school staff and administrators were given a list of 44 potential issues relating to mental health and asked to name the five most frequent issues that students approached them with or that they observed themselves. The most prevalent responses are presented in Figure 17.

Figure 17. Most prevalent mental and behavioral health issues addressed at school.
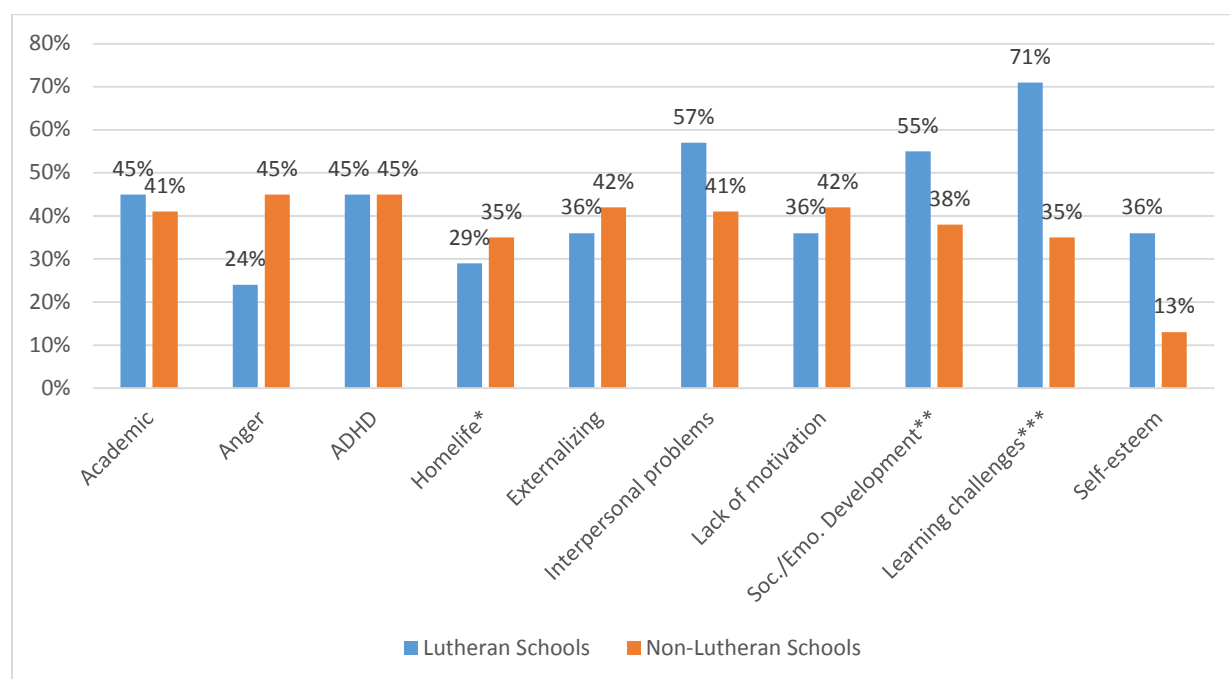
* Combines caregiver neglect, caregiver abuse, caregiver behavior, and problems/conflicts with caregivers.
** Combines separate categories of social development and emotional development.
*** Combines cognitive development and learning challenges.

School survey data revealed no differences between Allen and the surrounding counties in the prevalence of particular mental health problems, but differences were noticeable between Lutheran and non-Lutheran schools. A larger percentage of respondents from Lutheran schools reported observing developmental issues and learning challenges, interpersonal problems, and issues with self-esteem than respondents from non-Lutheran schools. Conversely, a larger percentage of respondents from non-Lutheran schools reported observing anger issues than did respondents from Lutheran schools.

Most of the issues identified by youth in focus groups as major concerns were consistent with findings from the school survey. Anxiety over academic performance and preparing for the future were very prevalent, as well as interpersonal conflicts, making friends, and fitting in. There was a great deal of anxiety expressed due to uncertainty regarding the economy, whether they should go to college, and what career to pursue. Participants felt that they weren't getting enough information, or were getting bad information, about what classes to take, or what else they should be doing. There was a sense of being overwhelmed by all of the academic requirements and high-stakes career planning, not to mention part time jobs, keeping up with chores and fitting in social activities. As one youth put it, "You have no clue how hard it is to be a kid."

According to the focus groups, adults and youth seem to have similar opinions of the major issues affecting youth today. Focus group participants stated that bullying, stress of school, and peer pressure are common among youth. As with the key informant interviews, participants cited cyberbullying as a major component of the bullying they see. Bullying and fighting was also

seen with groups of friends. Several participants mentioned self-esteem issues including stereotyping, disliking their appearance, and feeling inferior to others. Self-esteem issues were also the most cited answer when teen survey respondents were asked about the most difficult things they faced.

The physician survey indicated ADHD, anxiety, depression, and oppositional defiant disorder as the leading issues they see in their pediatric patients. They also noted that youth are often treated with prescription medication but not at the same rate as adults.

Substance Abuse

Results of the household survey indicate moderate but significant differences in substance use among groups. Statistical analyses were limited to comparisons based on income levels, age, gender, White versus non-White, Black versus non-Black, and Allen County residents versus residents of other counties. Based on these comparisons, the following differences were observed:

➢ Allen County residents were statistically more likely to have consumed alcohol in the last 30 days than residents of other counties (x^2 = 4.6268, p = 0.031);

➢ Residents outside of Allen County were statistically more likely to have used marijuana (x^2 = 4.0601, p = 0.044);

➢ Males are statistically more likely than females to both smoke (x^2 = 12.2664, p = 0.000) and drink alcohol (x^2 = 7.8786, p = 0.005);

➢ Non-Whites are statistically more likely than Whites to take someone else's medication (x^2 = 4.8474, p = 0.028);

➢ Non-Blacks are statistically more likely to consume alcohol (x^2 = 6.4673, p = 0.011);

➢ Smokers statistically tend to have lower incomes than non-smokers (t = 2.0654, p = 0.0198); and

➢ Those who drink tend statistically to be younger (t = 2.0887, p = 0.0187) and have higher incomes than those who do not (t = -5.5858, p = 0.000).

Nearly all respondents perceived at least a slight risk in misusing prescription medications, consuming 3 or more drinks per day, and using tobacco, marijuana, or other illegal drugs. However, men overall perceived less risk on a statistically significant level than did women in consuming 3 or more drinks each day (t = -3.6591, p = 0.0001), in using tobacco (t = -3.2477, p = 0.0006) and marijuana (t = -3.4613, p = 0.0003), and in using other illegal drugs (t = -2.3493, p = 0.0096). They also perceived less risk in mixing alcohol with prescription (t = -4.2514, p = 0.0000) or over-the-counter medications (t = -2.6425, p = 0.0043).

Separate from the risks involved, respondents were asked how wrong it was to use different substances. Figure 18 shows the percentage of respondents who believed it is not wrong to engage in a range of behaviors related to ATOD use.

Figure 18. Percentage of respondents who believe it is not wrong to engage in a range of behaviors.
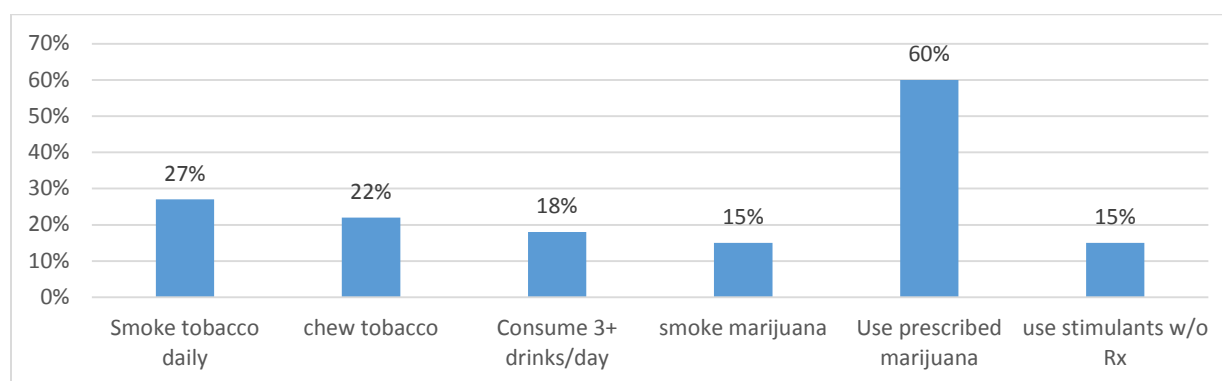
Compared to the behaviors in Figure, lower percentages of respondents believed it was acceptable to use pain medication without a prescription (8%), to take more of a prescription than recommended (95%), to take prescriptions without a doctor's orders (4%), or to take over-the-counter medication differently than instructed (10%).

There were also differences between subgroups regarding their perception of how acceptable it was to engage in certain behaviors. Compared to men, women perceived it to be more wrong to consume 3 or more drinks per day ($t = -1.8156$, $p = 0.0351$), to smoke ($t = -1.8156$, $p = 0.0351$) or chew tobacco daily ($t = -2.5385$, $p = 0.0058$), to use stimulants ($t = -1.7611$, $p = 0.0395$), to use non-prescribed marijuana ($t = -1.7060$, $p = 0.0444$), to take more of a prescription than recommended ($t = -1.6847$, $p = 0.0464$), or to take prescriptions without a doctor's orders ($t = -1.6469$, $p = 0.0502$). Acceptance of the use of medical marijuana was more prevalent among those with lower incomes ($t = 2.4741$, $p = 0.0069$), while taking more of a prescription than recommended was more acceptable among individuals with higher incomes ($t = 1.6298$, $p = 0.0520$). The use of chewing tobacco ($t = -2.8625$, $p = 0.0022$) and medical marijuana ($t = -3.0275$, $p = 0.0013$) were also more acceptable among younger respondents.

According to the senior mental health needs assessment conducted by Praxis, residents in the Northeastern counties of the state saw greater risks regarding substance abuse and misuse than other regions. They were statistically more likely to perceive risks in drinking alcohol, using tobacco (cigarettes and chewing), and misusing prescription medication.

It is still worth noting that while large majorities of respondents indicated that it is wrong to use illegal drugs or to misuse prescriptions, when asked if most of the people in their communities were anti-drug, the majority answered negatively. There appears to be a misperception regarding the general acceptance of drug use, since the majority of respondents feel like they hold a minority opinion in this regard.

Key informants mentioned not only dependence on licit and illicit mind altering substances, but also addictive or compulsive behaviors that lead to obesity and other unhealthy physical conditions as serious problems in their communities. Nevertheless, the majority of key informants were concerned with addiction and substance abuse. Many felt that substance abuse was a generational issue that needed to be addressed as much in the home as in schools,

churches, community centers, and courts. Although social stigma surrounding substance abuse is seen as less severe than stigma surrounding mental illness, many correlated substance abuse and mental health; some drugs were portrayed as causing symptoms of mental illness such as psychosis to emerge, others were seen as substances used by individuals who desire to treat anxiety, stress, and depression but who ultimately aggravate these conditions.

Key informants repeatedly mentioned the following substances as highly prevalent in their counties: prescription drugs, alcohol, methamphetamine, and synthetic or designer drugs. Also mentioned were marijuana, tobacco, crack, cocaine, heroin, and krocodil. Alcohol abuse is an issue of particular importance among immigrant populations, seniors, adults, and young adults. Methamphetamine is of major concern in rural communities in which community members perceive the drug as pervasively prevalent and highly correlated with domestic conflict and sexual abuse of both women and children. Crack was reported as more prevalent in urban communities, and a handful of respondents—particularly members of the law enforcement community—cited heroin as an issue in their communities.

Prescription drug abuse was mentioned as an alarming phenomenon across all demographics. Key informants felt that adults and seniors were abusing prescription pain medications at high rates. Recreational or non-medical use of prescription drugs has its counterpart in self-medicating adults and seniors with physical ailments that they treat by taking either medication prescribed to them or to their friends, families, spouses, or partners.

Many key informants active in education reported that students are at high risk for developing mental health and substance abuse problems for a number of reasons. Over-achievers were portrayed as over-stressed and overwhelmed by the expectations imposed on them to achieve excellence in academics as well as in extra-curricular activities. Abuse of prescription drugs, namely the stimulants Ritalin and Adderall, was cited as prevalent among this group. Many respondents were concerned with rates of substance abuse among youths, especially recreational use of prescription pills, synthetic drugs, marijuana, and tobacco. Addictive behaviors were often attributed to poor domestic conditions or parental neglect or abuse, not to mention generational substance abuse issues in the home and poor quality of life.

Key informants also reported licit synthetic drugs as posing a serious problem in their communities, especially among youths who experiment with these readily available drugs and who may in turn experience symptoms including psychosis. Spice or K2 and Bath Salts are the synthetic substances most frequently mentioned. One respondent working in the school system expressed her concern that some parents have no problem with their children abusing these drugs because they are not illegal. Countywide bans in Indiana and across the United States are lessening access to these drugs or criminalizing them. Nevertheless, the number of respondents concerned with rates of synthetic drug abuse in their communities signals that these substances represent an issue meriting the consideration of prevention advocates and policy-makers.

Key informants recognized over-prescribing medications as a big problem. Some individuals reportedly become accidental addicts following surgeries or dental procedures for which they are prescribed far more pills than they require for pain symptoms, etc. One respondent gave her 15-year-old son as an example; according to her, he was prescribed 90 pills when far less would

have been appropriate. There was the perception that youths with an excess of pills or access to parents' or grandparents' medications will distribute them among their peers.

Where mental health and substance abuse intersect, there was concern expressed in focus groups regarding a tendency to "medicate, not educate". The concern was that either individuals would self-medicate with alcohol or other drugs, or doctors would immediately prescribe psychotropic drugs to treat symptoms because it was faster and easier than addressing the underlying cause of the problem. They felt that there should be more holistic treatments to address the root cause of a mental health problem.

Protective Factors

Key informants and focus group participants alluded to a number of diverse protective factors for their communities. In rural areas, parks departments were reportedly quite active in providing opportunities for outdoor leisure activities, such as hiking. In Steuben for example, the Parks Department appears to be quite active in promoting activities at Pokagon State and encouraging activities at the 101 lakes to which residents have access. In Huntington County, informants indicated that there is a strong cycling culture.

In most counties, churches were reportedly active in promoting wellness. In Wells County, an informant mentioned food and furniture drives organized by the church to help families in need. Key informants also cited local clubs such as the Eagles in DeKalb and the Lions Rotary Club in Wabash as protective factors.

There are several individuals and organizations mentioned in the interviews who are regarded as leaders striving to help others in their community. In Allen County, community leaders such as Judge Charles F. Pratt, whose "40 Assets for Kids" is helping Allen County communities, including immigrants and refugee groups, and Judge David Avery, referred to by a key informant as the face of "a judicial system with a heart," were lauded for their service. In Allen County, a new Veterans Court has been established to help curb the criminalization of veterans who are in need of mental health and substance abuse services. In Wabash County, there is an initiative in place called the Wabash Promise, a program that gives kids K-3 the opportunity to have savings accounts to assist them in saving for college. With regard to protective factors for inmates, at the Wabash Valley Correctional Facility there is a program in place called Choices, which promotes wellness by guiding inmates to make the right choices. And in Allen County, the Blue Jacket organization gives direction to ex-offenders (convicts). In Adams County, Adams Memorial Hospital (AMH) is lauded for its outreach efforts; Dr. John Gibson, Director of Behavioral Health Services at AMH was mentioned as a key figure in the work being done there. In Huntington County, Huntington University offers counseling services; a key informant mentioned Lifespring, a free clinic that plans to submit a grant proposal to The Lutheran Foundation for expanding its services.

Using data from the household survey, researchers conducted a multitude of statistical tests to identify trends among subgroups relating to protective factors and community support. Table 1 summarizes the findings based on the statistically significant results of those tests for select subgroups.

Table 1. Adult protective factors.

Those with lower incomes…	• Feel less trust for their family (t = 1.9513, p = 0.0259) • Spend less time with friends (t = -2.1579, p = 0.0158) • Are more likely to feel that they were on their own "when the going gets tough" (t = 2.3729, p = 0.0091) • Engage in fewer social activities (t = -3.5732, p = 0.0002) • Attend fewer religious services (t = -3.1497, p = 0.0009) or other faith-centered group activities (t = -1.8398, p = 0.0333) • Are more likely to feel that their community is full of drugs (t = 1.8678, p = 0.0313)
Those with higher incomes…	• Were less likely to have a family (t = 1.4379, p = 0.0756), but, when they did, had better relationships with their families on all five positive measures of family support (t = -2.4556, p = 0.0072) (t = -2.7533, p = 0.0031) (t = -2.5640, p = 0.0054) (t = -3.1187, p = 0.0010) (t = -2.0386, p = 0.0211) • Are more likely to be able to count on friends for help if they have a problem (t = -2.0390, p = 0.0211) • Are more likely to feel that the people they live with are a team (t = -3.4337, p = 0.0003) • Are more likely to report good social (t = -1.6317, p = 0.0518) and recreational (t = -2.6391, p = 0.0043) programs in their communities • Are more likely to feel that people in their community care about each other (t = -2.4733, p = 0.0069)
Lone adults in a household… (no other adults, with or without children present)	• Are less likely to have a family (t = -4.0806, p = 0.000) • Feel less connected to the family they do have (2 measures: t = 6.2489, p = 0.000; t = -2.0619, p = 0.0199) • Perceive less support from family (3 measures: t = 5.2858, p = 0.000; t = 6.0669, p = 0.000; t = 3.1171, p = 0.001) • Feel less trusted by family (t = -1.9084, p = 0.0285) and feel less trustful of family (t = -2.3540, p = 0.0095) • Are more likely to feel that "when the going gets tough you are on your own" (t = -4.6334, p = 0.000) • Engage in fewer social activities (x^2 = 13.1868, p = 0.000) • Attend fewer religious services (t = 1.9038, p = 0.0288) • Are more likely to feel that people don't care about each other (t = 1.8296, p = 0.0340) • Are more likely to perceive a lack of good recreation programs (t = 1.6707, p = 0.0478 • Are more likely to describe their neighborhood as high crime (t = 2.9028, p = 0.0020) • Are less critical of city services generally (t = 2.6950, p = 0.0037)
Those who are retired …	• Believe that most people keep their problems to themselves (t=-2.1266, p=0.0170) • Are more likely to have friends (t=-2.0113, p=0.0225) • More likely to feel safe in their community (t=-2.0857, p=0.0188), but still feel you have to you have to watch your back (t=-2.0046, p=0.0228) • Engage in fewer social activities (x^2 = 5.7875, p = 0.016)

Compared to the rest of the sample, Blacks were…	More likely to… • Attend faith-centered group activities (t = -2.0536, p = 0.0203) • Feel that they were on their own "when the going gets tough" (t = -1.7001, p = 0.0449) • Feel that there are good recreation programs available in their community (t = -1.8264, p = 0.0343)
Compared to the rest of the sample, Whites were…	More likely to… • Have at least one friend they could count on to "be there" for them (t = -2.4058, p = 0.0083) • Feel safe in their communities (2 measures: t = -3.04500, p = 0.0012; t = -2.2122, p = 0.0138) • Feel city services in their area are a joke (t = -3.5513, p = 0.0002)

Some of the distinctions between Whites and Blacks may be more due to their location. Most of the Black population lives in Allen County, while the surrounding counties are predominately White. Comparisons of residents of Allen County versus residents of the surrounding counties reveal statistically significant distinctions that align with some of the racial distinctions noted above, specifically those regarding city services and recreation programs.

Tests comparing residents of Allen County to residents of the surrounding counties also revealed surprising characteristics of these surrounding counties. The traditional image of rural America is one of tight communities and close-knit families. However, this image was not supported by survey data. Family support reported in the household survey was very similar across all counties. Allen County residents agreed more with the statement "my family doesn't know much about my life" (t = -2.2486, p = 0.0125), but there were no significant differences in any of the other nine measures of family support. Compared to residents of Allen County, residents of the surrounding counties were more critical of recreational (t = -3.2349, p = 0.0007), social (t = -2.6538, p = 0.0041), and educational (t = -3.5504, p = 0.0002) programs in their communities and were much more likely to describe city services in general as a joke (t = 7.4800, p = 0.0000). They also perceived less support from friends on three different measures, though they did perceive more support on one measure. Specifically, they were less likely to agree with the following statements…
  ➢ I have at least one friend I can count on to be there for me (t = -1.93914, p = 0.0266);
  ➢ I can count on my friends (t = -1.9391, p = 0.0266);
  ➢ I expect to have the same friends next year (t = -1.6521, p = 0.0496); and
  ➢ Most of the people I hang out with like to keep their problems to themselves (t = -2.7712, p = 0.0029).

The youth survey included the same range of questions as the household survey regarding protective factors and community support. The results of this portion of the youth survey are as follows:
  ➢ 46% of youth felt that it was hard to talk to their family about their problems, though 95% stated they could count on their family to help them if they needed something;
  ➢ 40% of the youth surveyed agreed that "most of the people I hang out with like to keep their problems to themselves";
  ➢ 18% of the students do not expect to have the same friends a year from now;

➢ 23% of youth respondents believed that their community is full of drugs. 86% of youth feel that their community is strongly anti-drug;
➢ 11% of youth feel that you have to watch your back in their community, though 97% agreed that they felt safe in their community. 76% said that they lived in a low-crime community; and
➢ 82% of youth respondents stated that religion is strong in their community.

Conclusions

Analyses and discussions of mental and behavioral health in The Lutheran Foundation service area travel along five distinct paths:
➢ Policy;
➢ Perception;
➢ Service Structure;
➢ Phenomena;
➢ Social Cohesion.

Policy

The policy issues intersecting with mental and behavioral health are many:
➢ The criminalization of people with mental and behavioral health problems;
➢ The crowding of a jail system that does not have the capacity to respond to people with mental or behavioral health issues;
➢ The adjudication of offenses based on their legal categorization rather than on individual mental and behavioral health assessments;
➢ The ossification of criminal courts *and* the material limits of building more responsive and effective court systems such as specialized Veterans, Substance Abuse, and Domestic Violence courts;
➢ The drift of schools, particularly publics, toward one dimensional, achievement-based activities and away from family and community support functions;
➢ The limits of third party carriers on mental and behavioral health payments, and the general costs of services;
➢ The formal or informal support for employees engaging mental and behavioral health services among employers.

Policy issues are intractable to the extent that The Lutheran Foundation cannot address them alone or even award sufficient grants to influence them substantively.

Perception

How individuals, organizations, and communities perceive mental and behavioral health has a profound impact on both access and policy. Key informant interviews and focus groups found that:
➢ Other than those executives directly engaged in the mental and behavioral health arena, most executives were not well informed about the issues and not particularly attenuated to specific "problems" in their communities;
➢ Focus groups and the community survey indicate that most people simply do not know how to access mental or behavioral health services. Even 211 was not widely or broadly mentioned;

➢ Both adult and youth focus group participants perceived mental and behavioral health services as stigmatizing and comparable to a negative admission of personal failure.

Structure

Structural issues are both social and institutional. They sometimes intersect with policy development, or a lack of policy development, as they influence mental and behavioral health. They include:

➢ Demographic trends, especially in non-urban areas that are simultaneously aging, shrinking and diversifying;
➢ The larger gaps in service, including services to lower-income and minority populations;
➢ The shortage of mental health professionals in The Lutheran Foundation service area;
➢ The capacity of institutions like jails and courts to become adaptive and to change with or without new resource allocations or resource realignments;
➢ The continuity of care sufficient to achieve positive therapeutic outcomes;
➢ The centralization of most mental and behavioral services, other than intake, in the urban hub of Allen County generally and Fort Wayne specifically, which makes travel to those service providers a challenge for residents of non-urban counties;
➢ The cost of mental and behavioral health services even when adjusted according to an income-based sliding scale. One participant in the African-American focus group observed that even $5.00 weekly for services could be burdensome for a poor or working poor family. On the other hand, she also acknowledged that people tend to not value or gain less from services they do not pay for somehow.

Phenomena

Phenomenologists would argue that the empirical existence of a phenomenon often masks the generators producing it. Suicide, for example, is tragic in itself, and that very condition may mask the generators—chronic anxiety, depression, stress, bipolarity, etc.—producing it. If nothing else, this needs assessment should underscore the extent to which many variables generate mental and behavioral phenomenon. This is to say that The Lutheran Foundation must address the generators more than individual phenomena when approaching mental and behavioral health issues. Unlike so many publicly funded and well-intentioned efforts—Drug Free Communities, Suicide Prevention Coalitions, etc.—The Lutheran Foundation needs to avoid becoming a "one-trick pony" and should remain cognizant of all the nuances at work in mental and behavioral health issues.

Social Cohesion

Protective factors—those attributes, activities, interactions, and "local" constructs that promote mental and behavioral well-being—are changing, if not weakening, in The Lutheran Foundation service area. The influences undermining protective factors include:

➢ The net population loss, aging, and racial and ethnic diversification of counties;
➢ The limited reach of organized religion;
➢ The increasing divergence of perceptions of authority, especially among minority and new American populations who may be suspicious of institutions of authority;
➢ The risk-tolerant attitudes of male populations toward substances;
➢ The explosion of pressures placed upon youth, well beyond traditional expectations of "good grades" and typical patterns of peer pressure;

- ➢ The diversification of social and cultural norms and behaviors that were once relatively homogeneous;
- ➢ The concentration of "hard" youth issues primarily in public schools;
- ➢ The devolution of schools, particularly public schools, into spaces with a narrow mandate;
- ➢ The lack of comprehensive mental and behavioral health facilities in the non-urban counties;
- ➢ The absence of family support mechanisms, especially for those dealing with severe and chronic mental health issues among family members.

Recommendations

The Lutheran Foundation is not a direct service provider; it is a grantmaker. In order to make grants that will contribute to the construction of communities and individuals enjoying mental and behavioral well-being, it should travel all of the paths noted in the previous section, but purposefully, forcefully, and distinctively so. It should drive a brand and, in turn, know what it wants to see as a net return on its investments. It should *remain* Christ-centered and *become* data-driven.

Policy and Perception

1. Assist the Fort Wayne interest group in congealing into a regional advocacy body speaking to both policy and larger structural issues in mental and behavioral health. The group should add organizations that have a policy orientation, such as Health Visions Midwest. The group should also address combating the stigmatization of mental and behavioral health. We would not recommend that the advocacy group formally incorporate. We would recommend that it adopt a more organized structure, iterate a mission, appoint officers or spokespeople, and make a concerted effort to keep mental and behavioral health issues in the forefront of public, community, and corporate policy development.

Structure, Phenomenon, and Social Cohesion

2. The Lutheran Foundation should initially place a priority on addressing Adams, Allen, and Noble counties, without necessarily excluding other counties from competing for grants. Adams, Allen, and Noble counties are the most stressed areas in The Lutheran Foundation's service area.
3. The Lutheran Foundation should emphasize funding initiatives that address building and expanding protective factors, especially in non-urban counties.
4. The Lutheran Foundation should focus its expansion and reconstruction of protective environments on:
   - ➢ Youth respite;
   - ➢ Male risk tolerant perceptions and attitudes;
   - ➢ Aging populations;
   - ➢ Adults, both male and female, living alone;
   - ➢ Minority and New Americans settling in traditionally White counties.
5. As part of building and reconstructing protective environments, The Lutheran Foundation should attend to the tractable issues of access, including:
   - ➢ Improving resource and referral networks;

- ➢ Sustaining care until positive therapeutic outcomes can be realized;
- ➢ Balancing personal cost and investment in the therapeutic process with the realities of poverty and working poor existence;
- ➢ Seeding or helping to seed expanded and accessible clinical services beyond case management and intake assessments in non-urban counties;
- ➢ Cultivating groups and networks that address the needs of families grappling with severe mental illness among family members;
- ➢ Seeding a systemic approach, beyond the often valiant efforts of primary care health providers, to address depression, anxiety, bi-polarity and other episodic and chronic emotional conditions through talk and behavioral therapy, in addition to drug therapies;
- ➢ Supporting schools and their allies to become reliable referral resources for youth and adults and to reestablish themselves as centers of family support and information; and
- ➢ Addressing stigmatization of mental and behavioral health.

Strategies

An approach to funding strategies that will make an impact on mental and behavioral health issues is as follows:
- ➢ Adopt a funding strategy that emphasizes collaboration building to address local and countywide mental and behavioral issues—such a strategy must include multi-year grants—and incorporate the development of measurable outcomes within each agency, participating collaboratively in the development of impact measures for local collaborations into the grant-making process.
- ➢ Make annual renewals dependent upon the submission of outcome and impact data.
- ➢ In order for The Lutheran Foundation to remain Christ-centered and to become data-driven, give the priority to proposals that incorporate at least one Lutheran (or any faith-based) ministry or congregation into its proposal.
- ➢ In order to create the highest possibility of success with collaborations, provide agencies and their collaborators with training and technical assistance in developing and measuring outcomes and impacts.
- ➢ Provide collaborative agencies with coaches, training, and technical assistance in their first year of work. The assistance should address capacity development, best practices, and utilization of evidence-based programming and tools, etc.